In Search of a Spearhead to Reduce Maternal Mortality in Indonesia

WOMEN RESEARCH INSTITUTE

Edriana Noerdin

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Acknowledgments

In 2010, Women Research Institute published a book entitled, *Target MDGs Menurunkan Angka Kematian Ibu Tahun 2015 Sulit Dicapai* (Reducing Maternal Mortality in 2015 Is Difficult to Achieve). The book was based on findings of research conducted by the WRI research team on the access and use of reproductive health facilities by poor women in seven districts, namely North Lampung, Lebak, Indramayu, the city of Surakarta, Jembrana, Central Lombok, and West Sumba. I have rewritten and refocused the book, and have given it a new title, *In Search of a Spearhead for the Reduction of Maternal Mortality in Indonesia.*

While rewriting the book, I conducted discussions and interviews with WRI researchers in order to obtain more information and revise the analysis and recommendations. I would like to thank WRI researchers, Erni Agustini and Sri Wahyuni whose additional information and rich insights from their research findings have helped me immensely in rewriting the book. I am also indebted to Sita Aripurnami, the Director of WRI, who has entrusted me to reinterpret the research findings and conclusions, and package them into a new book. The completion of this rewritten book owes much to Sekar Pireno, WRI's Publication and Campaign Manager, for her relentless reminders of the deadlines and always-women-

friendly design as well as concept that WRI is very much up to. Last, but not least, I would also like to thank Alexander Irwan for having challenged me critically in interpreting the data, analysis and recommendations.

By publishing this book I particularly aim at providing inputs to policy makers to enable them develop and implement maternal mortality reduction programs effectively.

Publisher's Preface

As a research institution, Women Research Institute aims to undertake studies through the use of gender analysis and feminist methodology. This kind of research will produce an analysis that shows how women are accepted by society, as well as how women see their community.

In the context of regional autonomy, the research undertaken by Women Research Institute always looks at the situation and experiences of women in various regions to obtain a comprehensive picture of how women are impacted by policies and development programs at the local level.

In Search of a Spearhead for the Reduction of Maternal Mortality in Indonesia hopes to bring insight which will guide decision-making to take steps to fulfill women's reproductive rights in general, and particularly to reduce the incidence of maternal mortality in Indonesia.

Thank you for Dr David Hulse, country representative of the Ford Foundation in Jakarta, who made this publication possible under Ford Grant No: 1100-0121 and IIE Program No: FF-5H016. His continuous support of many of those who work on Sexual and Reproductive Rights has had an enormous impact on the conditions of women sexual reproductive health in Indonesia.

This publication may also encourage people to envision issues in terms of a feminist perspective, and to translate their thoughts into feminist practice and analysis. It is hoped that this publication will shed light on the inequalities of rights to reproductive health services in order to reduce maternal mortality in Indonesia. Edriana Noerdin offers new angles and perspectives in analyzing this important challenge.

Jakarta, February 2011
Women Research Institute

Glossary

3T	: 3 kinds of delays in treatment, i.e., tardy diagnosis, tardy decision-making and tardy treatment; *Terlam-bat mengetahui, Terlambat mengambil keputusan, dan Terlambat menerima pertolongan*
AKI	: Maternal Mortality Rate; *Angka Kematian Ibu*
APBD	: Regional Development Budget; *Anggaran Pendapatan dan Belanja Daerah*
APBN	: National Development Budget; *Anggaran Pendapatan dan Belanja Negara*
APN	: Normal Childbirth Training, *Asuhan Persalinan Normal*
ASB	: Standard spending analysis; *Analisa Standar Belanja*
Askes	: Health insurance for civil servants; *Asuransi Kesehatan*
Askeskin	: Health insurance for impoverished citizens; *Asuransi Kesehatan Masyarakat Miskin*
Aurat	: Parts of the body that should not be exposed, according to Islamic law
Balita	: Child under five years of age; *anak di Bawah Lima Tahun*

Bappenas	: National Planning Development Agency; *Badan Perencanaan dan Pembangunan Nasional*
Batita	: Child under three years of age; *anak di Bawah Tiga Tahun*
Belis	: West Sumba; bride price given by the groom's family to the bride's family in the wedding ceremony
Bidan	: Biomedical trained midwife
Bides	: Village Midwife; *Bidan Desa*
BKD	: Regional Personnel Board; *Badan Kepegawaian Daerah*
BP	: Treatment Center; *Balai Pengobatan*
BPS	: Central Statistics Bureau; *Biro Pusat Statistik*
D1	: Professional certificate for one-year program
D3	: Professional certificate for three-year program
DAK	: Special Allocation Grants; *Dana Alokasi Khusus*
DAU	: Block Grants; *Dana Alokasi Umum*
Desa Siaga	: Village Alert System
Dukun	: Traditional healer
Dukun bayi	: Traditional midwife
FGD	: Focus Group Discussions
FITRA	: Indonesian Forum for Budget Transparency; *Forum Indonesia untuk Transparansi Anggaran*
Gakin	: Impoverished Family; *Keluarga Miskin*
GBHN	: Outlines of State's Direction/National (State's) Guidelines; *Garis-Garis Besar Haluan Negara*
GDI	: Gender-related Development Index, measurement of achievement in dimensions similar to HDI indicators, but captures inequality between women and men. The greater the gender inequality in basic human development indicators, the lower the GDI of a country is in relation to its HDI.
GEM	: Gender Empowerment Measure, measurement in gender empowerment, used to evaluate progress of a country in empowering women in fields of economy and politics, including political decision-making.

GSI	: Love Mom Movement; *Gerakan Sayang Ibu*
HB	: Hemoglobin
HDI	: Human Development Index, *Indeks Pembangunan Manusia*
HDR	: Human Development Report
HIV/AIDS	: Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPI	: Human Poverty Index
IBI	: Indonesian Midwives Association; *Ikatan Bidan Indonesia*
ICU	: Intensive Care Unit, *Unit Gawat Darurat*
IMR	: Infant Mortality Rate
Immunization BCG	: Bacillus Calmette-Guerin. BCG is the vaccine to prevent tuberculosis (TBC)
Immunization DPT	: Diptheria-Pertussis-Tetanus
IUD/AKDR/Spiral	: Interuterine Device; contraceptive that is inserted into the vagina, made of pliant plastic; some kinds of IUD/spirals are made of copper or a coppersilver mixture. Copper IUDs can be used for 4-10 years.
Jamkesmas	: Social Health Security; *Jaminan Kesehatan Masyarakat*
Jamkesnas	: National Health Insurance; *Jaminan Kesehatan Nasional*
Jamu	: Herbal drinks used for treatment of health problems
JKJ	: Jembrana Health Insurance; *Jaminan Kesehatan Jembrana*
JPS	: Social Security Network; *Jaring Pengaman Sosial*
KB	: Family Planning; *Keluarga Berencana*
KDS	: Health Fund Group; *Kelompok Dana Sehat*
Kesling	: Environmental Health; *Kesehatan Lingkungan*
KIA	: Maternal and Child Health; *Kesehatan Ibu dan Anak*
KIE	: Communication, Information and Education; *Komunikasi, Informasi, dan Edukasi*
KMS	: Health Card for children under five years old; *Kartu Menuju Sehat*

KRR	: Youth Reproductive Health; *Kesehatan Reproduksi Remaja*
Lansia	: Senior Citizen; *Lanjut Usia*
Linakes	: Childbirth Assisted by Medical Personnel/*Persalinan oleh Tenaga Kesehatan*
Luruh duit	: Lit., 'reaping money' (Indramayu); women in their productive years become commercial sex workers for family income
Menkes	: Ministry of Health; *Menteri Kesehatan*
MDG	: Millenium Development Goal
MMR	: Maternal Mortality Rate
MPS	: Making Pregnancy Safer Movement
Musrenbang	: Development Planning Assembly; *Musyawarah Perencanaan Pembangunan*
Ngakuk mulei	: Lampung; bride price given by the groom's family to the bride's family in the wedding ceremony
NTB	: West Nusa Tenggara; *Nusa Tenggara Barat*; a province in eastern Indonesia
NTT	: East Nusa Tenggara; *Nusa Tenggara Timur*
Ojek	: Motorcycle taxi
PAD	: Net Regional Incomes; *Pendapatan Asli Daerah*
Pamau	: West Sumba; sons who are the protectors of the family assets
PAUD	: Early Childhood Education; *Pendidikan Anak Usia Dini*
PIN	: National Immunization Week; *Pekan Imunisasi Nasional*
PKK	: Advancement for Family Welfare, women's association in every hamlet/ward; *Pembinaan Kesejahteraan Keluarga*
PMKK	: Clinic Performance Management Training; *Pelatihan Manajemen Kinerja Klinik*
PMI	: Indonesian Red Cross; *Palang Merah Indonesia*
PMT	: Provision of Additional Meals; *Pemberian Makanan Tambahan*

PNS	: Civil Servant; *Pegawai Negeri Sipil*
POD	: Village Medicine Post; *Pos Obat Desa*
POGI	: Indonesian Society of Obstetricians and Gynaecologists; *Perkumpulan Obstetri Ginekologi Indonesia*
Polindes	: Village Maternity House; *Pondok Bersalin Desa*
PONED	: Basic Obstetric and Neonatal Emergency Care; *Pelayanan Obstetrik Neonatal Emergensi Dasar*
Pos UKK	: Health Ventures Post; *Pos Upaya Kesehatan Kerja*
Posyandu	: Integrated Services Post; *Pos Pelayanan Terpadu*
Promkes	: Health Promotion; *Promosi Kesehatan*
PTT	: Temporary Employee; *Pegawai Tidak Tetap*
Puskesmas	: Community Health Center; *Pusat Kesehatan Masyarakat*
Pusling	: Mobile Puskesmas*; puskesmas keliling*
Pustu	: Sub-community Health Center; *puskesmas pembantu*
Rembugan	: Discussion; refers to cultural practice in Lebak where the family discusses the condition of a woman in labor and makes the decision on whether to seek medical help or not
RSUD	: Regional Public Hospitals; *Rumah Sakit Umum Daerah*
SDKI	: Indonesian Demographic and Health Survey; *Survei Demografi dan Kesehatan Indonesia*
SIMO	: License to store medicine; *Surat Ijin Menyimpan Obat*
SJSN	: National Social Security System, *Sistem Jaminan Sosial Nasional*
SKN	: National Health System/*Sistem Kesehatan Nasional*
SKM	: Community health graduate; *Sarjana Kesehatan Masyarakat*
SKTM	: Poverty Identification Cards; *Surat Keterangan Miskin*
SPK	: Midwife Education School; *Sekolah Pendidikan Kebidanan*
SPM	: Minimal Service Standards; *Standar Pelayanan Minimal*

STD	: Sexually Transmitted Diseases, *Infeksi Menular Seksual*
TT	: Tetanus Toxoid immunization
UKBM	: Community-Based Health Ventures; *Upaya Kesehatan Bersumber Daya Masyarakat*
UKM	: Community Health Unit; *Usaha Kesehatan Masyarakat*
UKS	: School Health Units; *Usaha Kesehatan Sekolah*
UNDP	: United Nations Development Program
UNFPA	: United Nations For Population Agency
UNICEF	: United Nations Children and Education Fund
Wali Songo	: First nine preachers of Islam in Java, revered as saints
WHO	: World Health Organization
WRI	: Women Research Institute
Yankes	: Health Service; *Pelayanan Kesehatan*

CHAPTER I
Introduction
The Persistence of High Maternal Mortality Rate in Indonesia

The National Planning Development Agency (Bappenas) states that the greatest challenge faced by the health sector in Indonesia today is the high Maternal Mortality Rate (MMR).[1] The MMR in Indonesia continues to be the focus of debates. Based on the international comparison method conducted by UNICEF, the "reported" MMR in Indonesia for 2000-2007 was 310, while the "adjusted" rate for 2005 was 420.[2] The Population Report 2008 of the United Nations For Population Agency (UNFPA) agrees with UNICEF that in 2005 the MMR in Indonesia was still as high as 420/100,000 live births.[3]

The MMR in Indonesia issued by those two international organizations is considerably higher than the national data for 2007[4] and 2009[5]

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[1] Badan Perencanaan Pembangunan Nasional (Bappenas - National Development Planning Agency), Summary Report: Millennium Development Goals, Indonesia 2007, p. 8.

[2] www.unicef.org: Indonesia: Statistics: Women.

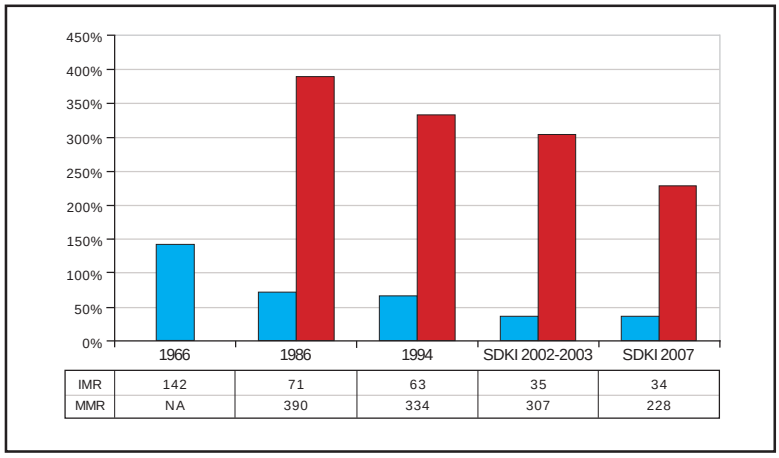
[3] *Kompas*, "Angka Kematian Ibu Dapat Diturunkan; Edisi Kesehatan Ibu dan Anak", January 23, 2010, p. 36.

[4] Badan Perencanaan Pembangunan Nasional (Bappenas - National Development Planning Agency), Summary Report: Millennium Development Goals, Indonesia 2007.

[5] Direktoral Evaluasi Pembangunan Sektoral, (Bappenas - National Development Planning Agency), Summary Report: Millennium Development Goals, Indonesia 2009.

issued by Bappenas that indicated that the MMR in Indonesia had decreased from 390/100,000 live births in 1994 to 307 in 2002-2003, and further decreased to 228 in 2008. Although the calculated national rate shows a decreasing trend (see Table 1.1[6]), Bappenas has indicated that it will be difficult for Indonesia to achieve the Millenium Development Goal (MDG) target of reducing the MMR to 102 by the year 2015. In both reports, Bappenas predicts that by 2015, the MMR in Indonesia will be in the range of 163. Indonesia is far behind the MMR of Malaysia and Thailand, which are 30 and 24 respectively,[7] and is closer to the rates of Vietnam (150), the Philippines (230) and Myanmar (380).[8] While the Indonesian government endorses the MMR produced by Bappenas, NGOs tend to trust the MMR issued by international institutions that use internationally comparable methods.

Graph 1.1.
Trends of Infant Mortality Rate and Maternal Mortality Rate (1966-2007)



IMR	142	71	63	35	34
MMR	NA	390	334	307	228

[6] Taken from the presentation by Roy Tjiong at the WRI book lauching for "Mengapa Target MDGs Menurunkan MMR tahun 2015 sulit dicapai?", March 24, 2010.

[7] www.unicef.org: Info by Country: Statistics: Women

[8] *Kompas*, "Angka Kematian Ibu Dapat Diturunkan; Edisi Kesehatan Ibu dan Anak", January 23, 2010, p. 36.

In an effort to understand the persistence of high MMR in Indonesia, WRI conducted research on the access and use of reproductive health services by impoverished women in six districts and one city in Indonesia, covering the districts of North Lampung, Lebak, Indramayu, Jembrana, Central Lombok, and West Sumba, and the city of Surakarta. It is important to conduct the research at the district/city level since after the introduction of decentralization in the early 2000s, many local governments have introduced policies and budget allocations that are not beneficial to the poor in general and women in particular. For example, regarding spending, Chapter II describes that only two out of WRI's seven selected districts/cities have fulfilled the mandate of the Health Law No. 36/2009 to allocate at least 10% of the APBD for health expenditures. Moreover, budget allocations specifically targeted for the improvement of women's health are less than 1% of the total local budget, except in the city of Surakarta.

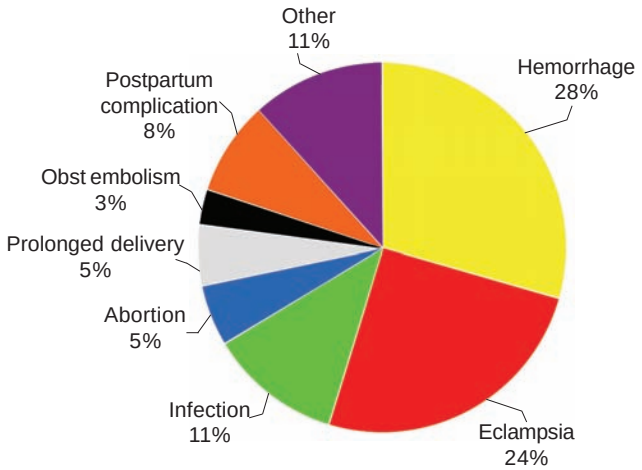
Concerning revenue, many local governments have raised the fees for public health services at the subdistrict health centers (*puskesmas*) and public regional hospitals (RSUD) that serve the poor who are not able to access private health services. Rather than providing free health services as mandated by the constitution, many regional governments require payment from the poor for the purposes of increasing their Net Regional Income (PAD). Data from the National Secretariat of the Indonesian Forum for Budget Transparency (FITRA) indicates that in 2009 fees from the *puskesmas* and regional hospitals provided 70% of the total PAD in Garut, 49% in Bondowoso, 48% in Parepare, 47% in Sumedang, and 43% in Boyolali, and there were at least nine other districts/cities where fees from health services provided more than 30% of the PAD.[9] The fees from the *puskesmas* and regional hospitals have raised the costs of health services and have had a negative effect on women from poor families who are the most economically vulnerable group in society. The fees have

[9] Seknas FITRA, "Analisis Anggaran Daerah di Indonesia: Kajian Pengelolaan APBD di 41 Kabupaten/Kota", 2010, p. 13.

reduced their ability to access health services for both general and reproductive health.

Lack of access to adequate reproductive health facilities contributes significantly to the persistence of a high MMR in Indonesia. The Director for Maternal Health Services in the Directorate General's Office for Community Health in the Ministry of Health, Dr. Sri Hermiyanti, reported that the Indonesian Demographic and Health Survey (SDKI) indicated that in 2008 the primary causes of maternal death were hemorrhaging (28%), eclampsia (24%), infection (11%), prolonged delivery (5%), and abortion (5%).[10] As can be seen in Graph 1.2, hemorrhaging and eclampsia caused 52% of the deaths of women in childbirth, whereas both of these are actually medical conditions that could be prevented or overcome if the mother is assisted by trained childbirth assistants in a childbirth facility that has adequate equipment and medical supplies. Those mothers die not only because they suffer from hemorrhaging and eclampsia, but also because they do not have access to adequate health and childbirth services, especially critical care and emergency services. There are three kinds of delays that cause maternal mortality in childbirth, and

Graph 1.2. Causes of Maternal Mortality



[10] *Kompas*, "Perdarahan Penyebab Kematian Ibu: Edisi Kesehatan Ibu dan Anak", Saturday, January 30, 2010, p. 13.

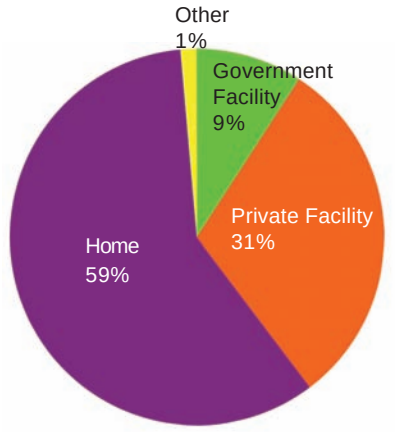
all of them are related to the lack of access to adequate reproductive health facilities:

- Delay in recognizing signs of danger and making decisions;
- Delay in reaching health service facilities;
- Delay in receiving service at health service facilities.

As stated in 1997 by Prof. Mahmoud Fathalla, Professor of Obstetrics and Gynaecology at Asslut University in Egypt, "women do not die because of an illness that cannot be treated. They die because the society has not yet decided that their lives are worth saving."

The three kinds of delays that often cause maternal death in childbirth are closely related to the fact that the majority of impoverished women, especially in rural areas, give birth at home. The figure in Graph 1.3. below indicates that 59% of all childbirths occured at home, while the remaining 41% took place at private and public childbirth or health facilities. Research results from the Mataram branch of the Indonesian Society of Obstetricians and Gynaecologists (POGI) also confirm the high rate of childbirth at home. In the 31 subdistricts in West Nusa

Graph 1.3. Place Chosen for Childbirth[11]



[11] Emi Nurjasmi, "Bidan Ujung Tombak Palayanan Kesehatan Ibu Anak", PP IBI, June 30, 2008.

Table 1.1.
Childbirth Attendents

Childbirth Attendents	%
Urban Areas	
- Doctor, General Practitioner	3.6%
- Gynaecologist	13.6%
- *Bidan*	61.8%
- Other	1.1%
- Traditional midwive-*Dukun*	19.9%
Rural Areas	
- Doctor, General Practitioner	0.9%
- Gynaecologist	4.6%
- *Bidan*	49.7%
- Other	2.1%
- Traditional midwive-*Dukun*	41.6%

Source: SDKI 2002-2003

Tenggara (NTB) that had high occurence of maternal mortality, 95.7% of all births occurred at home, where 85% of the mothers were assisted by traditional midwives (*dukun*), and 32% of them were assisted by untrained *dukun*. Only 2.6% of the births in the region occurred in hospitals.

The SDKI data in Table 1.1. shows that at the national level there still were many *dukuns* in rural areas in 2002-2003. The data from Graph 1.4. indicates that, as reported by Emi Nurjasmi from the Indonesian Midwives Association (IBI), 31.5% of the total cases of childbirth are handled by *dukun* and usually occur in private homes. The results of WRI's research show that *dukuns* are still the preferred choice as birth attendants in impoverished areas, while in the towns and cities and in regions that are not classified as impoverished, trained biomedical midwives (*bidans*) are the primary choice as birth attendants. WRI's research findings indicate that childbirths that took place at home and are attended by *dukuns* often encounter difficulties, such as the lack of clean water, electricity for lighting, sterile space and equipment, and necessary medicines, all of which carry risks for the health and safety of the mother.

There are four main reasons for impoverished mothers to give birth at home and be assisted by a *dukun*, even though it carries a high risk of

death. WRI research[12] shows that the four reasons make it very difficult for pregnant women in the rural areas to switch from *dukun* to *bidan*. The first reason is the lack of finances, which is discussed in detail in Chapters IV and V. This fact is confirmed by the results of POGI's research in Mataram, West Lombok, which showed that 81% of mothers reported that they could pay only Rp. 10,000 (US$ 1=Rp. 9,000) for childbirth expenses.[13] Related to the lack of expenses is the considerable distance between the *puskesmas* and RSUD, which is aggravated by poor road infrastructure and the lack of public transportation. In the seven areas of WRI's research, impoverished mothers said that their first choice for a childbirth assistant was a *dukun* because of their relative proximity and because they could be summoned to their house for the birth (see Graph 1.5.). It is not that they are unaware that doctors and *bidans* have much better medical expertise than *dukuns*; they actually understand that a *dukun* is not recommended for medical reasons (see Graph 1.6.). However, the cost of a *dukun's* services is much more affordable and can be paid in kind.

The second reason is, as described in Chapter V, that the kinds of services offered by a *bidan* are not as complete as those offered by a *dukun*. Services by a *dukun* are not limited to pre-natal care and delivery, but also include care for the newborn infant and the entire family. The third reason is more spiritual in character. Many *dukuns* are considered to have spiritual power that can provide comfort and assurance to mothers who are about to give birth, in labor, or have recently given birth. The fourth reason is the cultural predicaments faced by many women in rural areas. Chapter VI discusses how impoverished women have little authority over their bodies, and that they do not make the decisions about where they will give birth, but must comply with the decisions made by their husbands and families.

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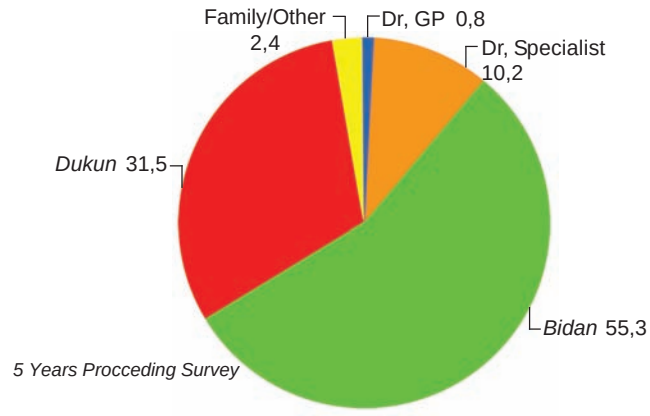
[12] WRI Research, *Akses dan Pemanfaatan Fasilitas Pelayanan Kesehatan Reproduksi bagi Perempuan Miskin di tujuh wilayah Penelitian*, 2007-2008.

[13] Results of annual POGI seminar, July 3, 2007, reported by the chairperson of the Mataram branch of POGI, Dr. Soesbandoro, Spog.

Graph 1.4.
Childbirth Attendents, IBI version[14]

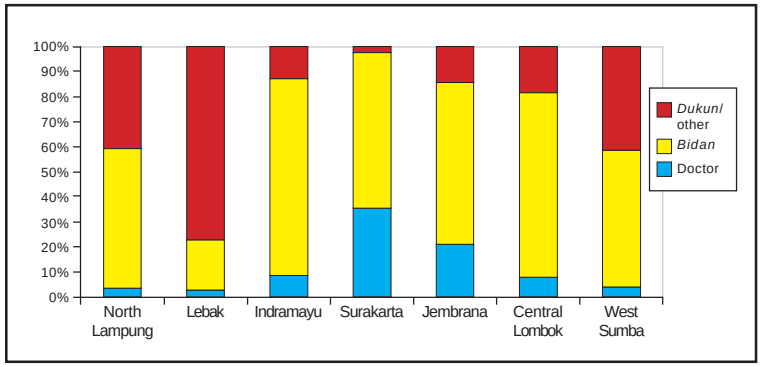


WRI research results also reveal several reasons other than expenses and cultural preferences that influence many women to choose a *dukun* to attend to them in childbirth, including:

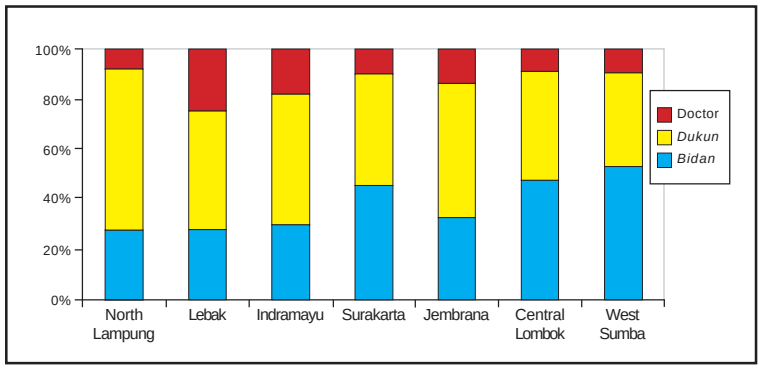
- The lower the educational level of the woman, the higher the frequency of choice for a *dukun*;
- The more children the woman has, the higher the frequency of choice for a *dukun*;
- The further away and more difficult the access to health facilities and personnel, the higher the frequency of choice for a *dukun*;
- The existence of guaranteed free health care does not decrease the frequency of the choice for a *dukun* by poor women in places such as Lebak, North Lampung and West Sumba, because the dissemination of information about free health services has been inadequate, and *dukuns* are easily accessible;
- The lack of a policy specifically concerning reproductive health for women, such as a program for a *bidan* to reside in the village;
- There are many young *bidans* that are assigned to serve in villages who are less experienced than older and more patient *dukuns*.

[14] Emi Nurjasmi, "Bidan Ujung Tombak Pelayanan Kesehatan Ibu Anak", June 30, 2008.

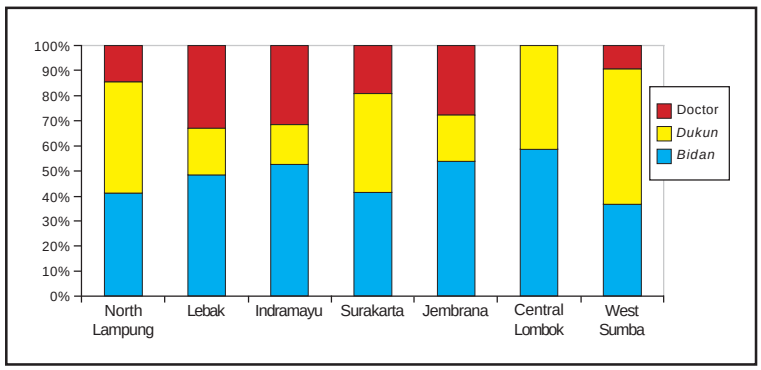
Graph 1.5.
Childbirth Assistants



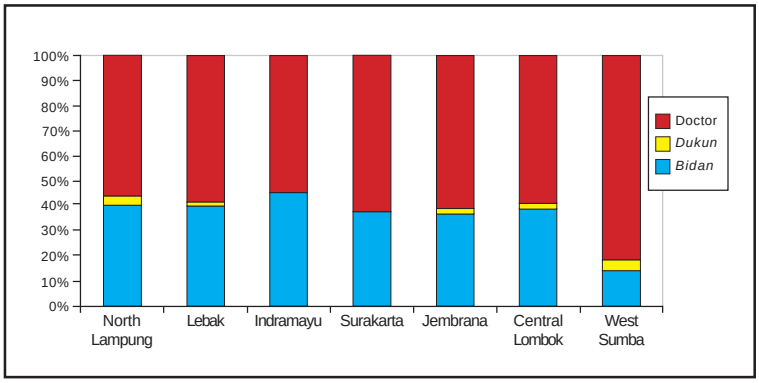
Graph 1.6.
Expenses as the Reason for Choosing Childbirth Assistants



Graph 1.7.
Distance as the Reason for Choosing Childbirth Assistants



Graph 1.8.
Expertise as the Reason for Choosing Childbirth Assistants



Government policy is also an important factor for the high number of childbirths at home. The high number of *dukuns* who assist births at home is not because of an insufficient number of *bidans* in Indonesia. Currently, while there are almost 71,000 villages in Indonesia, according to IBI (as seen in Table 1.2.), there are actually more than 83,000 *bidans*. This means that there are more *bidans* than villages in Indonesia. The problem is that, as stated in Chapter III, *bidans* are not equally distributed across districts and cities, and within a district/city they tend to cluster around the *puskesmas* at the subdistrict level and the hospitals at the city level. The government is not yet responsive to the need for health service facilities in the villages and has yet to issue a policy and provide sufficient financial incentives for *bidans* to live in villages, especially those in remote areas. The more isolated the village, the higher the MMR. The MMR in Papua, based on data from the provincial office of the Ministry of

Table 1.2.
Number and Distribution of *Bidan*, 2006

Number of *Bidan*	Distribution of *Bidan*
In Hospitals	10,086
In *Puskesmas*	20,831
In Villages	52,091
Total	83,008

Source: Ikatan Bidan Indonesia (IBI)

Health, is 396 per 1,000 live births and the infant mortality rate is 52 per 1,000 live births.[15]

Besides the number and unequal distribution of *bidans*, especially village *bidans* (*bides*), as shown in Table 1.2., the information in Table 1.3. reveals other problems faced by *bidans* in assisting childbirth in villages, especially remote villages. These problems can however, be overcome with government policies that provide incentives for *bidans* to live in these isolated villages, including provision of adequate housing, transportation, facilities and medical equipment. However, instead of issuing policies that would bring adequate health facilities closer to the homes of impoverished women in rural areas, the government has only introduced sporadic policies that do not sufficiently address the difficulties of poor women _in accessing adequate birthing facilities.

For example the central government, is currently attempting to overcome the problem of the limited availability of health personnel, both doctors and *bidans*, with the introduction of the Temporary Employee Program (PTT). According to the Ministry of Health, PTT doctors assigned in remote *puskesmas*, who formerly received wages of Rp. 1.5 million each month, will receive an incentive, i.e., a four-fold increase in wages. PTT doctors who have served for two years will be permitted to continue their studies for their medical speciality. *Bidans* assigned to a health service facility in a remote area will receive an incentive of Rp. 2.5 million each month. However, this policy has reached only as far as the sub-district level, and doctors and *bidans* are still not interested in living in villages, especially remote ones. There has yet to be any integrated policies that provide decent housing with has adequate facilities (electricity, clean water and sanitation) and medical equipment for assistance in childbirth to encourage *bidans* to live in villages.

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[15] *Djubi* tabloid, "Angka Kematian Ibu Melahirkan di Papua Capai 396 per 1.000 Kelahiran Hidup," http://tabloidjubi.com.

Another partial effort by the central government to reduce the MMR is the "Love Mom Movement" (GSI) that was launched by the president on December 22, 1996. The government implemented GSI through various strategies. First, the government introduced the Making Pregnancy Safer Movement (MPS). Second, the government developed an effective partnership through a cooperative cross-sector program to advocate the maximal use of available resources and improve coordination of MPS planning and activities. The implementation of GSI used a decentralized approach based on Act No. 22 (1999), Act No. 25 (1999), and a Government Regulation concerning the GSI Manual (Kepmen No.75/Kep/MenUPW/X/1997). The most dominant challenge in implementing the GSI program in the regions has been limited funds for program operation because not all regions are aware that they must allocate special funds for the improvement of health or empowerment of women.[16]

Ten years later, to better optimalize the implementation of the GSI program, the government issued a policy through the Ministry of Health's Decision No. 564/Menkes/SK/VIII/2006 concerning the development of a Village Alert System (*Desa Siaga*). This policy has become the foundation for local governments to provide early assistance to women in labor by optimalizing the resources owned by the community in the area. However, the keys to the success of the GSI and the Village Alert System programs are, in reality, contingent upon the political will of the local governments to provide budget allocations, and not many local governments have done so. Most districts are reluctant to allocate funds for health programs in general and for drastically reducing MMR in particular.

The results of FITRA's research on the Regional Development Budget (APBD) in 41 districts/cities shows that there is a minimum allocation of funds from the regional budget for health purposes. Only 12 of the 41 districts/cities in the research areas allocated 10-16% of their APBD for health, while the remaining districts/cities allocated less than

[16] Erni Agustini in Edriana Noerdin, et al., *Potret Kemiskinan Perempuan*. WRI. 2006

10%.[17] The percentage of the budget allocation for health is minimal in comparison to the budget allocation for education as mandated by the National Law (UUD 45), which is set at 20% of the national budget. As consequence, the implementation of the GSI program for the past ten years and the PTT program for the past three years have yet to show any success in overcoming the distribution gap of *bidans* and other childbirth assistants, resulting in the continuation of the high number of mothers giving birth in their homes and being assisted by *dukuns*.

It is disheartening to see that the national government has not been responsive to successes of *bidan-dukun* partnerships in reducing MMR, as described in Chapter V. Several local governments, including Central Lombok, Indramayu and Takalar, have shown strong political will to drastically reduce the number of births assisted by *dukuns*. The results of WRI's research in seven regions conducted in 2007-2008,[18] as seen in Table 1.4., show that impoverished districts, such as Central Lombok and Indramayu, were able to reduce the number of childbirths assisted by *dukuns* to under 20%, approaching the achievement of the City of Surakarta that has a far better health service infrastructure and transportation system, and the district of Jembrana that provides free health service for all of its residents. The achievements of Indramayu and Central Lombok were possible because of local policies that promote a partnership between *bidans* and *dukuns* as childbirth assistants. In this partnership pregnant women consult the *dukuns* during their pregnancy, but they go to the *bidans* for assistance in the birthing process. The district of Takalar in South Sulawesi has become the first district in Indonesia to have a Local Regulation that has been validated by the local legislature concerning the *bidan-dukun* partnership.[19] However, there have been no serious

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[17] Seknas FITRA, "Analisis Anggaran Daerah di Indonesia: Kajian Pengelolaan APBD di 41 Kabuten/Kota", 2010, p. 32.

[18] Women's Research Institute, "Akses dan Pemanfaatan Fasilitas Pelayanan Kesehatan Reproduksi Bagi Perempuan Miskin", 2007-2008.

[19] *Kompas*, February 1, 2010. http://id.news.yahoo.com/kmps/20100201/tls-perda-pertama-kemitraan-dukun-bidan-8d16233.html

Table 1.3.
Problems a *Bidan* Encounters as a Childbirth Assistant

Identification of Problems for Childbirth Assistants (*Bidan*) in 7 Research Areas: West Sumba, Central Lombok, Jembrana, Surakarta, Indramayu, North Lampung and Lebak

Facilities and Equipment	Quantity and Quality	Social Geography	Policy
• Lack of village birthing centers (*polindes*) in every village; those that do exist are not suitable for use. • Facilities of *polindes* are very minimal; many *polindes* are not yet equipped with electricity, clean water, and have only two rooms. • As a result, *bidans* do not want to live at the *polindes,* and they choose to assist births at their own practices/ houses. • Location of *the polindes* is far from the villagers' houses. • *Bidans* have minimal equipment, for instance, only HB measurement equipment, mini dopler, pregnancy test, dull set of delivery implements, and no lighting equipment. • Not all *bidans* have access to transportation. • *Bidans* needs administrative assistants to help complete their work reports. • In several cases of private ownership of *polindes*, there is a possibility of transfer of ownership. • Guarantee of security for *bidan* is low, whereas they must pay for the operational costs of the *polindes*. • Many *puskesmas* and branch *puskesmas* (*pustu*) do not provide childbirth services because they do not have facilities for overnight care.	• The distribution of *bidans* is uneven, especially in remote areas. • Some villages do not have a *bidan* in residence; they have only a health aide (*mantri*) in the village. • Education of *bidans* varies: 85% have Diploma I and 15% have Diploma III. • *Bidans* are rarely provided with training from the Ministry of Health, such as Normal Childbirth Training (APN). • The number of *bidans* sent for further education is still minimal. • There has not yet been comprehensive reproductive health training for *bidans*.	• The society still believes in the effectiveness of *dukuns*. • There is no health security for *bidans* assigned to work in remote areas. • Poor road conditions and limited transport hamper *bidans* work and make access to patients difficult. • Awareness of reproductive health among women is still low. • Family and cultural values still play a major role in determining reproductive health decisions.	• The regional government does not pay adequate attention to the welfare of *bidans*. • Not all claims for health insurance (Askeskin) are paid by the government; payment is dependent on the availability of funds. • Insurance (Askeskin) claims take a long time (6 months) to clear, or sometimes clear only at the end of the year, making *bidans* reluctant to serve Askeskin patients and they are forced to ask for cash for payment. • The criteria for hiring a *bidan* as a civil servant is not clear. • The wages for a temporary *bidan* are often paid 3 - 6 months late.

efforts by the central government to develop a national program to replicate the partnership's best practices in other districts in the country.

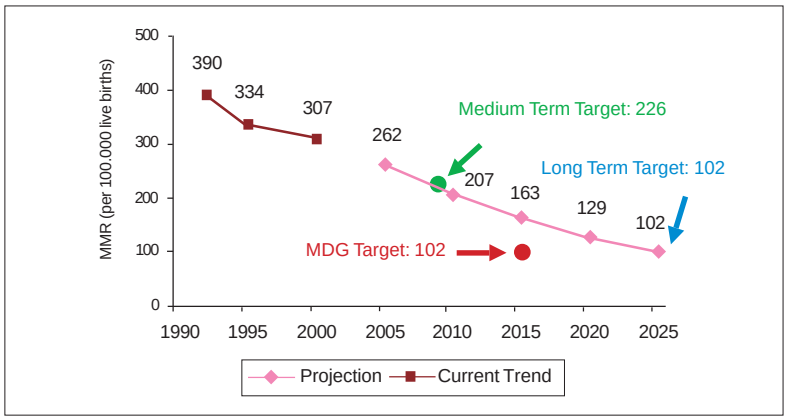
Table 1.4.
Childbirth Assistants in Seven Areas of WRI Research, 2007-2008

Childbirth Assistant	Lebak	North Lampung	Sumba	Surakarta City	Jembrana	Central Lombok	Indramayu
Doctor, GP	1.0	1.3	0.7	4.3	3.3	1.3	0.3
Doctor, Specialist	1.3	1.7	2.7	31.0	17.7	5.7	8.7
Bidan	21.3	55.3	54.7	62.7	64.3	74.3	78.7
Dukun/other	76.3	41.7	41.7	2.0	14.6	18.7	12.3

Table 1.5.
Incentives for Health Personnel

No.	Medical Professional and *Bidan*	Amount of Incentive
1.	Doctor/Dentist with Specialty assigned to health service facility in Remote and Very Remote Region	IDR 7,500,000,-
2.	Doctor/Dentist assigned to health service facility in Remote and Very Remote Region	IDR 5,000,000,-
3.	*Bidan* hired with criteria for Remote Region and serves in health service facility in Very Remote Region	IDR 2,500,000,-

Graph 1.9.
Brief Status of Millenium Development Goals, Indonesia 2009



The question of why many poor women, especially those who live in rural areas, choose to give birth at home and be assisted in childbirth by a *dukun* essentially, due to the government's lack of political will and budget allocations. Fundamental policy reform is needed to significantly reduce the number of impoverished women who give birth at home and are assisted by a *dukun*. What should be done if the RSUDs in the cities, the *puskesmas* in sub-district centers, and even the *bidans* that live in the center of the villages are considered by impoverished women who live in remote areas to be too expensive and too far away? WRI's research on the "Access and Use of Reproductive Health Service Facilities for Poor Women in Seven Districts/Cities in Indonesia" is dedicated to the search for a spearhead to bring reproductive health facilities closer to the homes of impoverished women in Indonesia. This book promotes the "One Village, One *Polindes*, and One *Bidan*" approach as the solution for tackling the persistence of the high MMR in Indonesia.

CHAPTER II
Lack of Political Will and Budget Allocation for Women's Reproductive Health

Health Law No. 36/2009 states clearly that all layers of the society must be able to access health services and that there must not be any differentiation between males and females in the implementation of services. According to the regulation, the government must base the development of health programs, including provision of public service, on gender equality. Article 3, Clause f of the law states,

> "… the implementation of healthcare must provide fair and equal service to all layers of society with affordable prices".

The statement "fair and equal service to all layers of society" is reinforced by the standard for gender equality in Article 3, Clause g, which states,

> "… development of health does not differentiate between women and men".

In further detail, Health Law No. 36/2009 stipulates that the central government must allocate a budget for health that totals at least 5% of the national budget (APBN), exclusive of wages. The provincial and dis-

trict/city regional governments are required to allocate a minimal budget of 10% of the local budget (APBD), exclusive of wages. It also designates that 2/3 of the total budget be prioritized for public services that are needed by the society to improve the standards of their health.[1] This shows that the central and local governments have legal bases to allocate budgets to develop programs for the reduction of the MMR. The question is how far the central and local governments have actually implemented the mandate stated in the laws for the financing and implementation of public services in health. It is the government's commitment and political will that will save the lives of poor women.

This chapter discusses WRI's findings concerning health spending based on research in six districts and one city that was conducted in 2007-2008. The data on budget allocations were taken from the APBD of 2007 of the research areas. What is the picture of health spending for poor women's health in the seven research areas?

Health Spending Policy in Seven Research Areas[2]

Budget allocations for women's reproductive health can be analyzed by looking at programs and their expenditures. The analysis is done by identifying programs and activities that are directly related to women's reproductive health and the reduction of the MMR. This study covers only the budget for women's reproductive health that is found in the areas of health and family welfare. WRI is aware that those programs and activities are not the only factors that contribute to the reduction of the MMR. Several other educational programs and activities also contribute to improvements in women's reproductive health, including safety in childbirth.

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[1] See Health Law No. 36/2009, Chapter XV, Article 170-172 concerning Health Financing.

[2] This section of this chapter is taken from the article by Yuna Farhan, entitled, "Menelusuri Kebijakan Alokasi Anggaran Kesehatan Reproduksi Perempuan di Tujuh Daerah", presented in the seminar "WRI Research Results concerning the Access and Use of Reproductive Health Service Facilities for Impoverished Women in Seven Regions in Indonesia", June 30, 2008.

An overview of the budget allocations for health in the seven research areas can be seen in Table 2.1. Only two of the seven districts/city, i.e., Jembrana (10%) and Lebak (10.7%), have actually fulfilled the mandate of Health Law No. 36/2009 to allocate a minimum of 10% of the APBD for health. It is interesting that Jembrana and Lebak, as can be seen in Table 2.2, are the districts with the lowest fiscal capacities. They have low Net Regional Incomes (PAD) and Production Sharing Funds that makes them dependent on Block Grants (DAU) from the central government. The fiscal capacity of Lebak is 10%, while Jembrana's is only 7%; both are far below the fiscal capacities of Indramayu and Surakarta, both of which reach 22%. Thus, it can be said that limited fiscal capacities should not prevent local governments from allocating larger budgets for health. If Jembrana and Lebak can fulfill the Health Law mandate to allocate a minimum of 10% of the APBD for health, then the other three districts whose fiscal capacities are approximately equal to those of Jembrana and Lebak, i.e., Central Lombok (9%), West Sumba (9%) and North Lampung (11%), and Indramayu and Surakarta, whose fiscal capacities are twice those of the other districts, cannot claim fiscal limitations as a suitable excuse. It is not a higher DAU or PAD that is needed to save the lives of poor women, but the political will of the government to fulfill the Health Law mandate to allocate of minimum of 10% from the APBD budget for health.

The percentage of the local budget allocation is actually not an accurate measurement of the budget needs for health because districts and cities have different population totals. The percentage of budget allocations for health can be more or less the same, but because the total population in Lebak is much higher than Jembrana, the budget allocation per capita for health in the two districts is vastly different i.e. Rp. 64,319 in Lebak and Rp. 151,043 in Jembrana. If we use the MDG target to determine the threshold of the budget for health, the target is a budget allocation for health of Rp. 120,000 per capita. Lebak has achieved just 50% of the MDG target, while Jembrana has exceeded the international target. Although Jembrana is a district with low fiscal capacity, the local government has a strong political will to prioritize spending for health.

Table 2.1.
Allocation for Health Spending

No.	Region	Health Spending		
		Total (IDR in millions)	% APBD	Per Capita
1.	Indramayu	73,646	7.3	41,838
2.	Central Lombok	42,725	7.1	51,740
3.	Lebak	75,662	10.7	64,319
4.	Surakarta	37,155	5.8	65,934
5.	North Lampung	43,593	8	74,857
6.	West Sumba	38,098	9	95,182
7.	Jembrana	38,887	10	151,043

Source: Data taken from APBD 2007 of 7 research areas

Table 2.2.
Fiscal Capacity of Seven Research Areas

No.	Region	Income (IDR)	Fiscal Capacity (IDR)	Capacity Fiscal (%)
1.	Indramayu	959,915	210,877	22
2.	Lebak	664,871	67,894	10
3.	Surakarta	590,132	129,910	22
4.	Central Lombok	571,075	54,123	9
5.	North Lampung	542,889	59,647	11
6.	West Sumba	395,144	37,421	9
7.	Jembrana	378,668	26,075	7

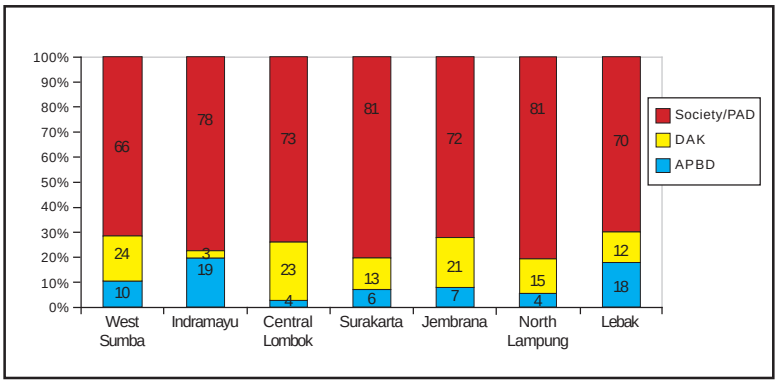
Source: Data taken from APBD 2007 of 7 research areas

Other than the amounts of budget allocation, sources of revenues should also be examined to determine whether the budget sides with the poor or not. In the local budget, the sources of health spending are differentiated between those that originate from health fees, Special Allocation Grants (DAK) and original local budget (APBD). More funds originating from health fees (PAD), indicate higher burdens on; the poor. Graph 2.1 shows that 18% and 19% of the health budgets in Lebak and Indramayu respectively come from health fees paid by residents. Thus, although Lebak has fulfilled the Health Law's mandate to allocate a minimum of 10% of its APBD for health, the local government has achieved this target by putting the burden on the society to pay for public health services. On the contrary, although Central Lombok, Surakarta, North Lampung, and

West Sumba allocate less than 10% of their APBD for health, they do not charge their citizens high fees for using public health services.

From this analysis it appears that health spending in Jembrana is the most "pro-poor" in comparison to the other six areas. First, its budget allocation for health fulfills the Health Law's mandate. Second, the spending for health per capita exceeds the MDG target. Third, the local government of Jembrana does not rely on fees for public health service as a source of their PAD. And, it must be remembered that the low fiscal capacity of Jembrana is not an obstacle for this district to apply its political will to allocate a health budget that takes side with the interests of the people in general, and the impoverished in particular.

Graph 2.1.
Expenditures Based on Source



Examining Expenditures for Women's Reproductive Health

Spending for women's reproductive health can be divided into two major sections, i.e., organization and program activities, where the program activities can be further divided into programs such as health affairs, Family Planning (KB) and family welfare. The objective of examining the expenditures for women's reproductive health in the seven research areas is to show how much, or to be more exact, how little, the budget is that is allocated for directly addressing the needs of women's reproductive health in general, and for childbirth in particular.

District of North Lampung

The district of North Lampung allocated 8% of its budget for health, equivalent to Rp. 75,000 per capita. This amount does not fulfill the mandate of Health Law No. 36/2009 nor the MDG target. 88% of this budget was allocated for the Health Service and 12% for the Regional Public Hospitals (RSUD). Of this amount, 54% was allocated for direct expenditures (4.32% of the APBD) and 47% for indirect expenditures (3.68% of the APBD). Of the 54% for direct expenditures, 9.04% (0.52% of the APBD) was used to finance administrative apparatus, such as equipment and infrastructure, while 38.73% (Rp. 16.8 billion) was used for the provision of the health infrastructure. Consequently, from the 8% of the health budget, expenditures that were used directly for the society amounted to only 3.8% of the APBD (Rp. 19.34 billion). If the funds from the Special Allocation Grants awarded by the central government (Rp. 6.6 billion) and from the health sector of the PAD (Rp. 1.5 billion) are subtracted from this amount, then the commitment of the North Lampung government from the APBD for health that was used directly

Table 2.3.
Expenditures for Programs and Activities of Health Services

No.	Program	Expenditures for Health		
		Total (IDR, in millions)	% of Health Budget	% APBD
1.	Administrative Apparatus	3,941	9.04	0.52
2.	Medicines and Health Provisions	1,543	3.54	0.27
3.	Community Health	278	0.64	0.05
4.	Health Promotion	82	0.19	0.01
5.	Improvement of Nutrition	66	0.15	0.01
6.	Development of Healthy Environment	86	0.2	0.01
7.	Handling of Infectious Diseases	3,21	0.74	0.06
8.	Standardization of Services	61	0.14	0.01
9.	Improvement of Equipment and Infrastructure	16,884	38.73	2.91
10.	Safety of Mothers in Childbirth and Children	27	0.06	0.005
11.	Upgrading the Role of the Community	257	0.59	0.04

Source: Data taken from APBD 2007 of North Lampung

for the society came to Rp. 11.2 billion, or 1.9% of the APBD. Table 2.3 shows that the expenditures for the safety of mothers in childbirth was the smallest portion of the budget, Rp. 27 million, or 0.06% of the total expenditures for health. This indicates that Health Services in North Lampung does not consider the safety of mothers and children to be a priority.

Besides the allocation under Health Services, women's reproductive health also receives budget allocation from programs for family planning and family welfare. These programs cover family planning (KB), youth reproductive health (KRR), contraceptive services, independent KB/KRR services, and family guidance counselors, with a total of Rp. 211.9 million, or 0.04% of the APBD. This means that the combined allocations for maternal and child health from the Health Services budget and the entire KB budget totaled only Rp. 238.9 million, or 0.1% of the APBD of North Lampung.

Table 2.4.
Expenditures for Women's Reproductive Health in the Family Planning Budget

No.	Program	Total (IDR)	% APBD
1.	Family Planning Program	40,000,000	0.01
2.	Youth Reproductive Health Program	23,500,000	0.004
3.	Contraceptive Services Program	55,050,000	0.01
4.	Training Program for Community Participation in Independent KB/KRR Services	35,000,000	0.01
5.	Training Program for Family Guidance Counselors	58,425,000	0.01
	Total	**211,975,000**	**0.04**

Source: Data taken from APBD 2007 of North Lampung

District of Lebak

In comparison to the other districts, Lebak allocated the highest amount from its budget for health: Rp. 75.6 billion (10.7% of the APBD), or Rp. 64,319 per capita. Although this amount fulfills the Health Law mandate, this budget allocation for health has not yet reached the MDG target of Rp. 120,000 per capita. This district also allocated much more for direct spending than the other districts. Direct expenditures for health

in Lebak reached 75.9% of the budget, or Rp. 57.4 billion, while indirect expenditures reached 24.1%, or Rp. 18.2 billion. However, upon further examination, it is revealed that spending for health in Lebak was divided into three Departments: Health Services, Regional Public Hospitals (RSUD), and the Social Welfare Service, all of which required funding for their administrative apparatuses, which came to a total of Rp. 11.2 billion. Thus, the spending on health that directly benefited the society actually only totaled Rp. 45 billion, or 6% of the APBD. If funds from the Special Allocation Grants from the central government that totaled Rp. 9 billion and the contributions from residents in the form of health fees that totaled Rp. 13.4 billion were subtracted from this amount, then the spending that went directly to programs and activities for the citizens that originated from the APBD was only Rp. 22.6 billion, or 3.2% of the local budget. This was the highest percentage from the APBD budgets of the seven research areas.

Tablel 2.5.
Expenditures for Programs and Activities of Health Services

No.	Program	Expenditures for Health		
		Total (IDR, in millions)	% of Health Budget	% APBD
1.	Administrative Apparatus	11,208	14.6	1.59
2.	Medicines and Health Provisions	4,550	6	0.65
3.	Community Health	783	1	0.11
4.	Health Promotion	147	0.2	0.02
5.	Improvement of Nutrition	8,692	11.5	1.23
6.	Development of Healthy Environment	922	1.2	0.13
7.	Handling of Infectious Diseases	497	0.7	0.07
8.	Health Services (*YanKes*) for the Poor	861	1.1	0.12
9.	Improvement of *Puskesmas* Equipment and Infrastructure	2,379	3.1	0.40
10.	Improvement of Hospital Equipment and Infrastructure	24,450	32.3	3.47
11.	Maintenance of Hospital Equipment and Infrastructure	700	0.9	0.10
12.	Health Resources	1,140	1.5	0.16

Source: Data taken from APBD 2007 of Lebak

In Lebak, the program that received the largest allocation was for the improvement of hospital equipment and infrastructure, which totaled Rp. 24 billion, absorbing more than half of the health budget outside of program expenditures for administrative apparatus. Funding for the third phase of construction of the Adjidarmo Hospital in Lebak shows that the local government prioritized infrastructure over the development of health services that are easily accessed by the poor. This is confirmed by the budget allocation through a regressive subsidy for secondary health services that benefits primarily the rich, since the poor have low access to general hospital services.[3]

Table 2.5 shows that there were no health programs in Lebak that explicitly addressed the issue of women's reproductive health in general, or reducing the MMR in particular. There were other budget allocations outside of health that concerned women's reproductive health and the MMR, such as family planning (KB) and Family Welfare. However, the amounts for these programs were small, totaling Rp. 5.7 billion, or 0.8% of the APBD. From this amount, Rp. 232 million, or 4.1% of the KB budget, was allocated for administrative apparatuses and only Rp. 900 million, or 0.13% of the APBD, was allocated for programs and activities related to women's reproductive health, as shown in Table 2.6.

Table 2.6.
Expenditures for Women's Reproductive Health in the Family Planning Budget

No.	Program	Total (IDR, in millions)	% Health Services	% APBD
1.	Family Planning Program	425	7.4	0.06
2.	Youth Reproductive Health Program	25	0.4	0.00
3.	Contraceptive Services Program	400	7.0	0.06
4.	Gender Mainstreaming	50	0.9	0.01
	Total	**900**	**15.7**	**0.13**

[3] World Bank, 2007. Study of Indonesian Public Expenses 2007: Optimizing a New Opportunity.

District of Indramayu

The district of Indramayu allocated Rp. 73.6 billion or 7.3% of its APBD for its health budget, making its per capita health expenditures Rp. 41,838. Not only did this amount fail to meet the Health Law's mandate, it was very far from the MDG target of Rp. 120,000 per capita. Out of the allocated budget amount, the portion dedicated for direct spending was 59%, or Rp. 43.4 billion (4.3% of the APBD). Of the direct expenditures, 37.2% (Rp. 24.5 billion) was allocated for Health Services and 16.7% (Rp. 11 billion) for the RSUD. Since the spending allocated for administrative apparatuses was Rp. 9 billion, the funds that were used for

Table 2.7.
Expenditures for Programs and Activities of Health Services

No.	Program	Expenditures for Health		
		Total (IDR, in millions)	% of Health Budget	% APBD
1.	Administrative Apparatus	9,099	13.8	0.96
2.	Medicines and Health Provisions	4,333	6.6	0.46
3.	Community Health	4,115	6.2	0.43
4.	Health Promotion	392	0.6	0.04
5.	Improvement of Nutrition	386	0.6	0.04
6.	Development of Healthy Environment	156	0.2	0.02
7.	Handling of Infectious Diseases	873	1.3	0.09
8.	Standardization of Services	164	0.2	0.02
9.	Health Services (*YanKes*) for the Poor	1,502	2.3	0.16
10.	Improvement of *Puskesmas* Equipment and Infrastructure	8,128	12.3	0.86
11.	Improvement of Hospital Equipment and Infrastructure	9,509	14.4	1.00
12.	Maintenance of Hospital Equipment and Infrastructure	203	0.3	0.02
13.	Partnership Program to Improve Health Services	935	1.4	0.10
14.	Program to Improve Health Services for *Balita*	71	0.1	0.01
15.	Program to Improve Health Services for *Lansia*	33	0.1	0.00
16.	Program to Supervise and Control Healthy Food	38	0.1	0.00
17.	Safety of Mothers in Childbirth and Children	18	0.0	0.005

Source: Data taken from APBD 2007 of Indramayu

programs and activities with direct benefits for the society amounted to only Rp. 34.4 billion, or 3.4% of the APBD. If contributions from the PAD that were generated from health fee payments by residents who were treated at health facilities, in the amount of Rp. 13.8 billion, and Special Allocation Grants that came to Rp. 2.1 billion, were subtracted from this amount, then the financing for health services that originated purely from the APBD that directly benefited the society was only Rp. 18.5 billion, or 1.8% of the APBD.

While the local government allocated Rp. 9.5 billion for the improvement of hospital equipment and infrastructure and Rp. 8.1 billion for the improvement of equipment for *puskesmas*, programs that were specifically aimed at improving the safety of mothers in childbirth received only a meager Rp. 18 million. This indicates that the problem of maternal mortality was not considered a priority by the local government. Expenditures for women's reproductive health that are related to Family Planning received a much larger budget, i.e., Rp. 1.03 billion, or 0.11% of the total APBD.

Table 2.8.
Expenditures for Women's Reproductive Health in the Family Planning Budget

No.	Program	Total (IDR, in millions)	% Health Services	% APBD
1.	Family Planning Program	376	4.9	0.04
2.	Contraceptive Services Program	67	0.9	0.01
3.	Guidance Program for Community Participation in Independent KB/KRR Services	397	5.2	0.04
4.	Program to Promote Mother, Infant and Child Health through Community Activity Groups	5	0.1	0.00
5.	Program to Develop KRR Information and Counseling Service Center	66	0.9	0.01
6.	Program to Improve Handling of Drug Abuse, STDs, including HIV/ AIDS	10	0.1	0.00
7.	Program to Develop Informational Materials about Child Development	36	0.5	0.00
8.	Training Program for Family Guidance Counselors	77	1.0	0.01
	Total	1,034	13.6	0.11

Source: Data taken from APBD 2007 of Indramayu

City of Surakarta

All health related matters in the city of Surakarta were placed under one unit, the Health Services, which received a budget allocation of Rp. 37 billion (5.8% of the APBD), or Rp. 65,934 per capita, a far cry from the minimum amount of 10% that is mandated by the Health Law. It is also nowhere near the MDG target of Rp. 120,000 per capita. 45.1% of the budget received by the Health Services was allocated for indirect spending, while 54.9% (Rp. 20.3 billion), or 3.2% of the APBD, was for direct spending. Of the direct expenditures, Rp. 3.9 billion was used to finance programs that support administrative apparatuses. Therefore, the budget allocation for health that had direct benefits for the citizens was Rp. 16.4 billion, or 2.5% of the APBD. If contributions from the health sector to the PAD totaling Rp. 2.3 billion, and the Special Allocation Grants from the central government that were allocated for equipment and infrastructure totaling Rp. 4.9 billion were subtracted from this amount, the funds purely from the APBD allocated for health services that directly benefited the society was only Rp. 9.2 billion, or 1.4% of the total 2007 APBD. The largest budget allocation outside the allotment for administrative apparatuses was for the improvement of equipment and infrastructure of *puskesmas* and hospitals. The allocation for equipment and infrastructure was a part of a Special Allocation Grant and was much larger than the budgets for the other programs and activities. The Health Services also allocated more for medicines and community health programs, as detailed in Table 2.9.

The specific program for the safety of mothers in childbirth and for children received an allocation of Rp. 441 million, or 0.07% of the APBD. In addition to this, the Family Welfare Unit in Surakarta that consists of the People's Social Welfare Service, Women's Empowerment Unit and Family Planning programs, received an allocation of Rp. 8.6 billion, or 1.3% of the APBD. 5.7% of the Health Services expenditures, or Rp. 493 million, were allocated for programs related to women's reproductive health, as presented in Table 2.10. The minimal amount of the allocation

Table 2.9.
Expenditures for Programs and Activities of Health Services

No.	Program	Expenditures for Health		
		Total (IDR, in millions)	% of Health Budget	% APBD
1.	Administrative Apparatus	3,944	10.6	0.62
2.	Medicines and Health Provisions	2,032	5.5	0.32
3.	Community Health	1,532	4.1	0.24
4.	Supervision of Food and Medicine	7	0.0	0.001
5.	Health Promotion	178	0.5	0.03
6.	Improvement of Nutrition	1,522	4.1	0.24
7.	Development of Healthy Environment	19	0.1	0.003
8.	Handling of Infectious Diseases	949	2.6	0.15
9.	Standardization of Services	411	1.1	0.06
10.	Improvement of *Puskesmas* Equipment and Infrastructure	5,403	14.5	0.84
11.	Improvement of Hospital Equipment and Infrastructure	2,916	7.8	0.46
12.	Maintenance of Hospital Equipment and Infrastructure	40	0.1	0.01
13.	Partnership Program to Improve Health Services	717	1.9	0.11
14.	Program to Improve Health Services for *Balita*	123	0.3	0.02
15.	Program to Improve Health Services for *Lansia*	133	0.4	0.02
16.	Program to Supervise and Control Healthy Food	17	0.0	0.003
17.	Safety of Mothers in Childbirth and Children	441	1.2	0.07

Source: Data taken from APBD 2007 of Surakarta

for these programs and activities is insufficient to solve the problems of women's reproductive health.

District of Jembrana

The district of Jembrana was the region with the highest allocation per capita for health spending, i.e., Rp. 151,043 per capita or Rp. 38.8 billion (10% of the APBD). Jembrana was the only one of the seven WRI research areas that fulfilled the mandate of the Health Law No. 36/2009 and exceeded the MDG per capita target health budget allocation. Reform of the bureaucratic structure by trimming and merging the Social

Table 2.10.
Expenditures for Women's Reproductive Health in the Family Planning Budget

No.	Program	Total (IDR, in millions)	% of Health Services	% APBD
1.	Family Planning Program	104	1.2	0.02
2.	Youth Reproductive Health Program	165	1.9	0.03
3.	Contraceptive Services Program	105	1.2	0.02
4.	Guidance Program for Community Participation in Independent KB/KRR Services	12	0.1	0.002
5.	Program to Promote Mother, Infant and Child Health through Community Activity Groups	39	0.5	0.01
6.	Program to Develop KRR Information and Counseling Service Center	26	0.3	0.004
7.	Program to Develop Informational Materials about Child Development	15	0.2	0.002
8.	Training Program for Family Guidance Counselors	12	0.1	0.002
9.	Program to Develop an Operational Model for BKB-*Posyandu*-PAUD Activities	15	0.2	0.002
	Total	493	5.7	0.09

Source: Data taken from APBD 2007 of Surakarta

Welfare unit into the Health Services unit improved expenditure efficiency for staff and increased the allocation for public spending on health.

The district of Jembrana allocated 60% of the health budget for direct spending (6% of the APBD), which was the second highest after Lebak that allocated 75% for direct spending. The Rp. 23.8 billion that was used for direct health expenditures came from Special Allocation Grants (Rp. 8.2 billion) and from the PAD generated by the health sector (Rp. 2.7 billion). Thus, Rp. 12.9 billion, or 3.2%, came from the allocation of Jembrana's APBD funds. However, it must be noted that Rp. 3.03 billion of the total direct health expenditures component was used for improving bureaucratic capacity and administrative apparatuses. This means that only Rp. 9.87 billion, or 2.4% of the total APBD, that was used for expenditures that provided direct benefits to the community actually came from APBD funds.

The district of Jembrana prioritized the Community Health Unit (UKM) by allocating a large 21% of the health budget (Rp. 8 billion) to the unit, which was partly used for financing individual health insurance for all Jembrana citizens. Moreover, the Health Services unit also financed the improvement of equipment and infrastructure for the *puskesmas* system, which showed that it prioritized health facilities that, compared to hospitals, were more easily accessed by the poor. The health sector made specific allocations for the safety of mothers and children in the amount of Rp. 300 million or 0.07% of the total APBD. On top of that, the Health Services unit also provided finances to preventive programs that contributed to women's reproductive health and the safety of mothers in childbirth.

Table 2.11.
Expenditures for Programs and Activities of Health Services

No.	Program	Expenditures for Health		
		Total (IDR, in millions)	% of Health Budget	% APBD
1.	Administrative Apparatus	3,033	7.8	0.80
2.	Medicines and Health Provisions	150	0.4	0.04
3.	Community Health	8,108	20.9	0.24
4.	Supervision of Food and Medicine	50	0.1	0.01
5.	Health Promotion	24	0.1	0.01
6.	Improvement of Nutrition	250	0.6	0.06
7.	Development of Healthy Environment	128	0.3	0.03
8.	Handling of Infectious Diseases	64	0.2	0.02
9.	Improvement of *Puskesmas* Equipment and Infrastructure	9,237	23.8	2.30
10.	Program to Improve Health Services for *Balita*	98	0.3	0.02
11.	Program to Improve Health Services for *Lansia*	40	0.1	0.01
12.	Program to Supervise and Control Healthy Food	20	0.1	0.01
13.	Safety of Mothers in Childbirth and Children	300	0.8	0.07

Source: Data taken from APBD 2007 of Jembrana

The bureaucracy for KB programs was streamlined and the unit was merged with the Labor and Civil Registry Services. The government allocated Rp. 170 million, or 0.038% of the APBD, for KB programs and activities. In total, combining funding from the Health Services and KB

budgets, women's reproductive health services received 0.1% of the APBD, or Rp. 470 million. Compared to the other districts, the total allocation in Jembrana was small. However, the availability of health insurance for all citizens contributed significantly to women's reproductive health.

Table 2.12.
Expenditures for Women's Reproductive Health in the Family Planning Budget

No.	Program	Total (IDR, in millions)	% Health Services	% APBD
1.	Administrative Apparatus	-	-	-
2.	Family Planning Program	50	0.9	0.01
3.	Youth Reproductive Health Program	56	1.0	0.01
4.	Contraceptive Services Program	56	1.0	0.01
5.	Program to Develop KRR Information and Counseling Service Center	2	0.1	0.004
6.	Program to Improve Handling of Drug Abuse, STDs, including HIV/ AIDS	1	0.02	0.000
7.	Program to Develop Informational Materials about Child Development	2	0.05	0.002
8.	Training Program for Family Guidance Counselors	3	0.1	0.002
	Total	170	4.17	0.038

Source: Data taken from APBD 2007 of Jembrana

District of Central Lombok

Central Lombok allocated Rp. 42.7 billion (7.1% of the APBD), or Rp. 51,740 per capita, for health spending, which was short of both fulfilling the mandate of the Health Law and the MDG's target allocation of Rp. 120,000 per capita. Rp. 25 billion (59% of the health budget) out of the total health spending was allocated for direct spending. However, budget allocations for strengthening the capacity and administrative apparatus (Rp. 2.6 billion), both of which do not produce direct benefits to the people, were included in the direct expenditures for health. Moreover, Rp. 10 billion of the health budget came from the Special Allocation Grants and Rp. 1.7 billion from health fee payments. This means that

funds that came purely from APBD amounted only to Rp. 10.6 billion or 1.8% of the total APBD.

The first priority of the health expenditures in the district was to improve the equipment and infrastructure of the *puskesmas* network, which totaled Rp. 15.6 billion, or 29% of the health budget. The second priority was to support the improvement of community health services, including the provision of pharmacy equipment in the amount of Rp. 4 billion. Central Lombok did not specifically allocate funds for programs for maternal safety or women's reproductive health. Although there were other activities related to maternal health, such as dissemination of information and meetings, they were not very substantial. Budget allocation for hospital equipment and infrastructure totaling Rp. 2.8 billion were not able to improve access by the poor to existing health services.

Table 2.13.
Expenditures for Programs and Activities of Health Services

No.	Program	Expenditures for Health		
		Total (IDR, in millions)	% of Health Budget	% APBD
1.	Administrative Apparatus	2,262	4.2	0.54
2.	Medicines and Health Provisions	93	0.2	0.02
3.	Community Health	6,024	11.3	1
4.	Supervision of Food and Medicine	7	0.0	0.001
5.	Health Promotion	320	0.6	0.05
6.	Improvement of Nutrition	517	1.0	0.09
7.	Development of Healthy Environment	497	0.9	0.08
8.	Handling of Infectious Diseases	1,037	1.9	0.17
9.	Standardization of Services	1,018	1.9	1.71
10.	Improvement of *Puskesmas* Equipment and Infrastructure	15,668	29.3	2.6
11.	Improvement of Hospital Equipment and Infrastructure	2,829	5.3	0.47
12.	Maintenance of Hospital Equipment and Infrastructure	116	0.2	0.02
13.	Partnership Program to Improve Health Services	105	0.2	0.02
14.	Program to Improve Health Services for *Balita*	441	0.8	0.07
15.	Program to Improve Health Services for *Lansia*	61	0.1	0.01
16.	Program to Supervise and Control Healthy Food	55	0.1	0.01

District of West Sumba

The district of West Sumba allocated a budget for health in the total amount of Rp. 38 billion (9% of the APBD), or Rp. 95,182 per capita. This amount almost fulfilled the mandate of the Health Law and was not far from the MDG's target of per capita allocation. Rp. 21 billion out of this total allocation (57%) was allocated for direct spending. However, the direct expenditure budget included funds for administrative apparatus in the amount of Rp. 653 million. Moreover, Rp. 9.2 billion of the health budget came from the Special Allocation Grants and Rp. 3.7 billion came from health fees paid by the people. Thus, the funds allocated by the West Sumba government for direct spending for health actually totaled only Rp. 7.3 billion or 2% of the APBD.

As in other impoverished districts that have poor infrastructure, the West Lombok government provided the largest health budget allocation, Rp. 12.6 billion or 27.7% of the health budget, for the improvement of *puskesmas* equipment and infrastructure. The amount of the allocation for physical infrastructure was a consequence of the Special Allocation Grants that required the use of the funds for the improvement of the health infrastructure. Thus, the expenditures for this program received a higher budget allocation in comparison to the other programs. Human resources for the health sector received the second largest budget allocation in the amount of Rp. 2.8 billion. A portion of this allocation was used to provide additional honorarium for health personnel. The Community Health program that included health insurance for the poor in the amount of Rp. 1.5 billion was the third priority.

Meanwhile, the budget for women's reproductive health specifically included programs to improve health services for *balita*; and activities such as training for prenatal care, information dissemination regarding reproductive health, healthcare training for the youth, training for peer guidance counselors, and validation of data for *bidan* counseling. The budget allocation for these activities totaled Rp. 110 million, or 0.03% of the APBD. Budget for Family Planning (KB) programs that contributed

to women's reproductive amounted to Rp 493 million, or 0.09% of the APBD. These programs were included in the Civil Registry and Family Planning Services. This means that West Sumba government allocated a total of Rp. 603 million, or 0.12% of the APBD, for women's reproductive health.

Table 2.14.
Expenditures for Programs and Activities of Health Services

No.	Program	Expenditures for Health		
		Total (IDR, in millions)	% of Health Budget	% APBD
1.	Administrative Apparatus	653	1.4	0.15
2.	Medicines and Health Provisions	1,329	2.9	0.31
3.	Community Health	2,001	4.4	0.47
4.	Supervision of Food and Medicine	17	0.0	0.00
5.	Health Promotion	83	0.2	0.02
6.	Improvement of Nutrition	149	0.3	0.04
7.	Handling of Infectious Diseases	236	0.5	0.06
8.	Health Services (*YanKes*) for the Poor	47	0.1	0.01
9.	Improvement of *Puskesmas* Equipment and Infrastructure	12,630	27.7	2.98
10.	Improvement of Hospital Equipment and Infrastructure	3,791	8.3	0.89
11.	Maintenance of Hospital Equipment and Infrastructure	140	0.3	0.03
12.	Partnership Program to Improve Health Services	1,394	3.1	0.33
13.	Program to Improve Health Services for *Balita*	145	0.3	0.02
14.	Health Resources	2,816	6.2	0.66
15.	Funding aide for DHS II Program	683	1.5	0.16
16.	Empowerment of Health Personnel	1,342	2.9	0.32

Source: Data taken from APBD 2007 of West Sumba

Table 2.15.
Expenditures for Women's Reproductive Health in the Family Planning Budget

No.	Program/Kegiatan	Total (IDR)	% Budget	% APBD
1.	Family Planning Program	123,550,000	2.8	0.03
2.	Contraceptive Services Program	673,275,000	15.2	0.16
3.	Program to Develop Informational Materials about Child Development	297,140,000	6.7	0.07
	Total	493,000,000	5.7	0.09

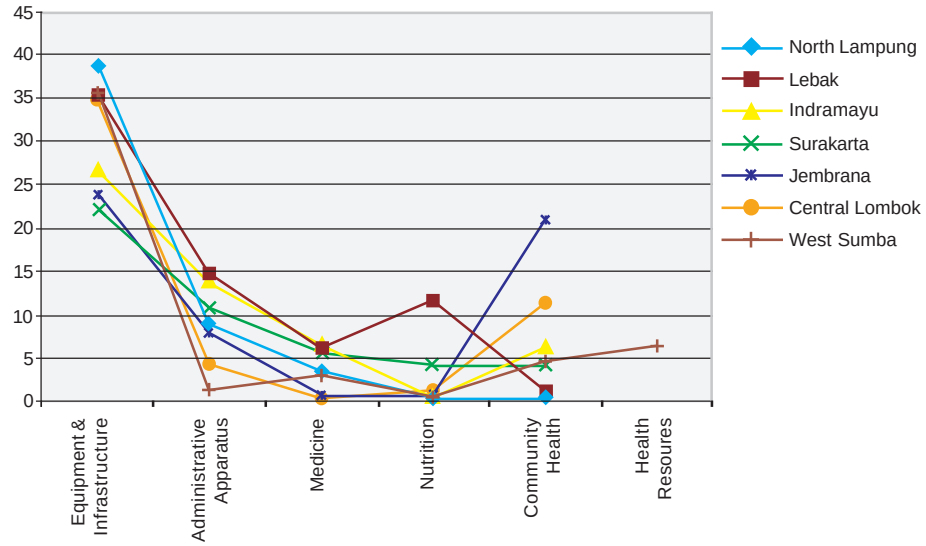
Source: Data taken from APBD 2007

Analysis of the Comparison of Expenditures for Women's Reproductive Health in Seven Research Areas

Graph 2.2. shows the similarities in the patterns of expenditures between the seven WRI's research areas. However, there are significant differences between Jembrana and the other districts/cities, as Jembrana has fulfilled the Health Law mandate and exceeded the MDG target in health expenditures per capita. In the seven research areas, the largest portion of health expenditures was allocated for equipment and infrastructure, and administrative apparatus. The amount of the allocations for equipment was attributed to the requirements of the Special Health Grants for the development of infrastructure. The spending for physical infrastructure was much higher than spending for programs and other activities. Jembrana stood out in comparison to the other research districts because of the combination of the low budget allocation for equipment and infrastructure and administrative apparatus, and the high spending for the Community Health Unit (UKM), which primarily financed the individual health insurance program for Jembrana residents.

Although there was a similar pattern of prioritizing the development of equipment and infrastructure, it must be noted that the allocations of the health budgets addressed the needs of the impoverished in different ways. For instance, while Lebak and Indramayu prioritized the improvement of equipment and infrastructure for hospitals, North Lampung allocated very high budgets for improving the equipment and infrastructure of the *puskesmas*, which are easier for the poor to access. Lebak, however, also allocated a significant budget for improving nutrition amongst the impoverished, which was not done by the government of North Lampung. It must also be noted that in some districts, specific expenditures for women's reproductive health and maternal childbirth safety programs can be found in the Health and KB units. For example, the Indramayu and Lebak, budgets for women's reproductive health were allocated in the KB units, which included activities for KB service and the handling of sexually transmitted diseases.

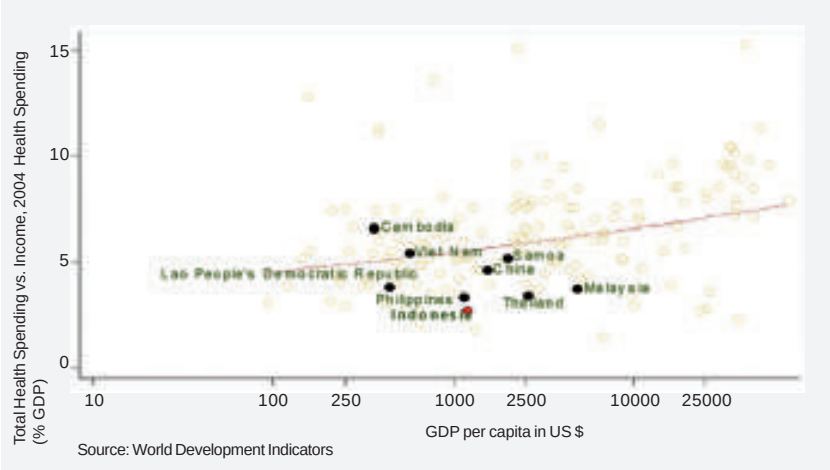
Graph 2.2.
Health Program and Activity Expenditures



Two of the seven research areas, i.e., Jembrana and Lebak, have fulfilled the mandate of the Health Law to allocate at least 10% of the APBD for health expenditures in general. The problem is that budget allocations for specific programs to improve women's health are too low. They amounted to less than 1% of the total budget, except in the city of Surakarta. It appears that it will take a considerable amount of time to effectively implement the 10% budget allocation mandate. The Health Law that promotes gender equality has not yet been able to induce local governments to allocate an equitable health budget, especially for maternal health, that is sufficient to assure the safety of women's lives in Indonesia.

The graph below confirms that Indonesia is one of the countries in Asia that allocates the smallest amount of its budget for health (2004). In Indonesia budget politics has not yet taken the side of the health sector. Politically, health is still seen more as a social expense rather than an investment. Therefore, hard works is requireds to increase the expenditures on health, both in general and specifically for women's health.

Graph 2.3.
Total Health Spending vs. Income, 2004



Health Law No. 36/2009 does indeed provide an opportunity to increase health spending in Indonesia and it can become a reference for increasing health expenditures, both in general and for women's health. There are two important matters concerning budgets in the seven research areas that must be addressed in the immediate future to advocate for a health budget.

- First, conduct a Standard Spending Analysis (ASB), which has never been done, to identify units and activities that are needed to reduce the MMR and improve women's reproductive health. The ASB will indicate how much is actually needed to reduce one case of maternal death, and the data can then be extrapolated to project the needed budget.
- Second, facilitate a space for women's groups to voice their needs, specifically in relation to reproductive health, in the Development Planning Assembly (Musrenbang). The voices of poor women would provide a boost for budget advocacy at the district/city and national levels.

CHAPTER III
Insufficient Quality and Quantity of Reproductive Health Workers

The number of health workers needed in a given region can be calcu lated with the use of the "Ratio Method" that is mandated by the Ministerial Decree 1202/Menkes/VIII/2003. This method calculates the ideal ratio of available health workers in the context of the total population of the area. This Ratio Method was used in determining the strategic indicators of the Healthy Indonesia 2010 Program. Table 3.1. shows the ideal number of health workers per 100,000 people. Each of the seven WRI research areas was analyzed with this Ratio Method.

Tabel 3.1.
Ideal Ratio of Health Workers in Total Population

No.	Health Workers	Ideal Ratio
1.	Doctor per 100,000 people	40
2.	Specialist doctor per 100,000	6
3.	Family doctor per 1000	2
4.	Dentist per 100,000	11
5.	Pharmacist per 100,000	10
6.	*Bidan* per 100,000	100
7.	Nurse per 100,000	117,5
8.	Nutritionist per 100,000	22
9.	Sanitation expert per 100,000	40
10.	Community health expert per 100,000	4

The results of the Ratio Method that will be discussed in this chapter show that five of the seven WRI research areas suffer serious shortages in the number of health workers for women's reproductive health. In one district, Jembrana, the number of health personnel is almost adequate, while in the city of Surakarta, there is an oversupply of nurses, both general and dental nurses. The excess of nurses in Surakarta is an example of the tendency of health workers to reside in urban areas. Although there is an oversupply of general and dental nurses in Surakarta, the city still suffers a significant shortage of general practitioners and *bidan*, although it is not as serious as the shortages in the districts of Lebak, West Sumba, Indramayu, North Lampung, and Central Lombok. Surakarta's oversupply of nurses is not a product of governmental budget policy since the city actually does not comply with the mandate of the Health Law No. 36/2009 to allocate a minimum of 10% of the APBD for health spending (Surakarta allocates only 5.8%). Nor does the city fulfill the MDG target to allocate a budget for health spending in the amount of Rp. 120,000 per capita (Surakarta allocates only Rp. 65,934). It appears that Surakarta's relatively good state of its urban infrastructure and the ability of its residents to pay for healthcare services have encouraged health workers to live in the city.

The results of the Ratio Method calculations for the district of Jembrana are interesting. Chapter II points out that Jembrana is the only district of the seven WRI research areas that fulfilled the Health Law's mandate, as Jembrana allocated 10% of it APBD for health, and the MDG target of Rp. 120,000 per capita (Jembrana allocated Rp. 151,043 per capita). The Ratio Method calculations show that although Jembrana still suffers from a shortage of general practitioners, specialist doctors, dentists, *bidans*, and general and dental nurses, the shortage is smaller than in the other districts. The shortage of health personnel in Jembrana was only 35%, while in West Sumba it was 62.3%, Central Lombok 66.6%, North Lampung 67%, Indramayu 82%, and Lombak 82%.

This data indicates that there is a positive correlation between the amount of health spending per capita with the supply of health workers,

as is indicated in the case of Jembrana. The conditions in Lebak reinforce this indication. Although Lebak allocated 10.7% of its APBD for health spending, exceeding the Health Law's mandate, because the total number of population of the district is high, the per capita allocation for health spending amounted only to Rp. 64,319, which is half of the MDG target. Because of this, it is not surprising that the shortage of health personnel in Lebak is worrisome.

Of course, the amount of spending is not the only factor to be considered. The allocation and use of expenditures also help to determine the availability of health personnel. For example, as discussed in Chapter II, both Jembrana and North Lampung prioritize the development of equipment and infrastructure of the *puskesmas* network. Better quality equipment and infrastructure in the *puskesmas* supports the availability of health workers. The shortage of health workers in Jembrana and North Lampung is relatively low, 35% and 67% respectively, in comparison to the shortages in Indramayu and Lebak, both 82%, where the priorities of the budget allocations are marked for improving the equipment and infrastructure of hospitals in the urban areas. The Community Health Unit (UKM) in Jembrana, which includes personal health insurance for all residents of Jembrana, may also be an influence on the district's relatively low shortage of health personnel. Indeed, more research is needed to uncover the exact relationship between budget allocations to improve the *puskesmas* network and the provision of health insurance for all residents with the availability of health personnel.

Availability of Health Workers and Health Services in West Sumba

The provision of facilities and health personnel in West Sumba was still far from adequate. Table 3.2. shows that the overall shortage of health workers in West Sumba in 2006 was 62.3%, while the shortage of *bidans* was 58.7%, and the shortage of nutritionists came to 90.9%. Not only were health personnel were in short supply, but they were also unevenly

distributed throughout the district. Health workers were concentrated in urban areas.

Table 3.2.
Ideal Ratio, Availability and Shortage of Health Workers in West Sumba

No.	Health Service Workers	Actual Number	Ideal Number	Shortage	Shortage (Percentage)
1.	Doctor	49	160	111	69.3
2.	*Bidan*	165	400	235	58.7
3.	Nurse	232	470	238	50.6
4.	Pharmacist	20	40	20	50
5.	Nutritionist	8	88	80	90.9
6.	Medical Technician	1	-	-	-
7.	Sanitation Expert	19	160	141	88
8.	Community Health Counselor	8	16	8	50
	Total	**502**	**1334**	**832**	**62.3**

Source: Data taken from the Annual Plan for Health Development, 2006, West Sumba.

The Health Department has conducted a number of efforts to improve the services of the *puskesmas* network by establishing *puskesmas pembantu* (*pustu*, sub-community health centre) and *puskesmas keliling* (*pusling*, mobile *puskesmas*) to reach isolated regions in West Sumba. However, the efforts were hindered by the small number of health workers. One staff member of the West Sumba Health Department said that:

> "… our problem here is how to get enough health workers to comply with the standard set by the Health Department. Each *puskesmas* must have two health workers, one professional and one assistant. It is very difficult for us to fulfill this requirement. At most, we can provide one health worker, and that person is usually a *bidan*. Since the Health Department has established the Village Welfare Post (*poskesdes*), whether we want to or not, we have no choice but to provide the post with whatever health service personnel are currently available."[1]

[1] *Target MDGs Menurunkan Angka Kematian Ibu Tahun 2015 Sulit Dicapai.,* Aris Arif Mundayat et.al., Women Research Institute, Jakarta, 2010.p. 159.

The shortage of health personnel is related to the ability of the local government to pay for the remuneration of health workers. Very few health workers have been willing to be assigned to West Sumba, especially to isolated, remote areas that are far from town centers. In the end, the local Health Department asked the central government for assistance:

> "We can only place our hopes on the central government. We will accept whoever the central government sends us. In the past, we requested the provincial government for health workers and they sent them to us. The mechanism was that the health workers were first assigned by the central government to the provincial level of East Nusa Tenggara (NTT). Many of them came from Sumatera but some of them were Sumbanese who signed a contract with the local government to return to the district after finishing their education.[2]

Doctors availability

Since there were only 49 doctors in West Sumba in 2006, there was a shortage of 111 doctors (69.3%). Of the 49 doctors, 12 were assigned to work in the *puskesmas* network and the remaining 37 doctors worked in two hospitals in the district capital. It was rare that doctors who were assigned to work at a *puskesmas* also lived in the village where he/she worked. They went to the villages only during working hours and chose to reside in towns or cities so that they could open private practices in their homes. Based on WRI's field observations, all three doctors that were assigned to serve in the *puskesmas* in Waikabubak lived in the towns of the sub-district because they had more patients in their private practices in the urban areas.

[2] *Ibid.*

Bidans availability

In 2006, the total number of *bidans* in West Sumba was 165, which was less than half of the ideal number of *bidans* for the district. This district needed an additional 235 *bidans* (58.7%) to reach the target health indicator of 2010 that 100,000 people should be served by 100 *bidans*, or 1,000 people per *bidan*. Currently, West Sumba has a population of 400,260 people, so one *bidan* must serve an average of 2,429 people, more than twice the ideal ratio.

Dr. Bonar Sinaga admited this shortage of *bidans* in West Sumba, especially village midwives (*bidan desa*, *bides*). The total number of villages in West Sumba in 2007 was 192 and the assignment of new *bides* reached approximately 70-80% of the villages. Not all of the *bides* lived in the villages in which they were assigned to work. An administrator in the West Sumba Health Department stated that many *bides* did not live in the villages where they worked because of lack of equipment and infrastructure for them and that there was concern for their safety. Despite this, the local Health Department continues to recruit *bides* to live in the villages.

Nurses availability

Nurses, popularly called *mantri*, are also often consulted for health treatments. There was a serious shortage of nurses in West Sumba in 2006. The district needed 238 more nurses or 50.6% of the ideal ratio for nurses. Usually, nurses serve as both the head and the administrator of the *pustu*, especially in remote villages where the nurse must be willing to undertake all of the *pustu* duties without any additional assistance. If the nurse is temporarily absent, then the patients have no access to any health services and must wait until the nurse returns because there are no alternatives for medical care. As is, the nurse's limited knowledge cannot provide medical care for serious health conditions. Therefore, the nurse must refer the patients to the nearest *puskesmas* or hospital. In many cases, such

as in Gaura village, many patients who were referred to the nearest *puskesmas* decided not go because the trip takes a long time. Instead, they turn to alternative choices, i.e., going to a traditional healer (*dukun*) to get traditional treatments, or doing nothing at all.

Availability of Health Workers and Health Services in Central Lombok

The shortage of health service workers in Central Lombok in 2007 was extremely serious. Table 3.3. shows that the shortage of general practitioners was 87.6%. For poor people who live in the remote rural areas access to doctors is difficult not only because of the shortage of doctors, but also because most doctors' practices in the district were in the city and town centers. Doctors who were assigned to certain subdistricts did not reside in their assigned villages. Patients from the rural areas had to go to the urban centers to consult a doctor.

Table 3.3.
Ideal Ratio, Availability and Shortage of Health Workers in Central Lombok

No.	Health Service Workers	Actual Number	Ideal Number	Shortage	Shortage (Percentage)
1.	Doctor, general practitioner	34	275	241	87.6
2.	Dentist	10	75	65	86.6
3.	Nurse	282	621	339	54.5
4.	*Bidan*	129	630	501	79.5
5.	Dental Hygenist	21	211	190	90.0
6.	Pharmacist	9	223	214	95.9
7.	Community Health Counselor	21	288	267	92.7
8.	Sanitation Expert	45	264	219	82.9
9.	Nutritionist	31	139	108	77.6
10.	Physical Therapist	1	30	29	96.6
11.	Anesthesiology Nurse	2	3	1	33.3
12.	X-ray Technician	1	3	2	66.6

Source: Data taken from the Annual Plan for Health Development, 2007, Central Lombok

Similarly, the shortage of *bidans* came to 79.5% of the ideal ratio. It can be assumed that the women did not receive adequate reproductive health services because the *bidans* must work as both health service providers at the *puskesmas* in the subdistrict center and be responsible for providing health service in the villages. The *bidans* went to the villages only when they were scheduled for duty at the monthly *posyandu* and then they returned to their posts at the *puskesmas*. Most of the *bidans* reside in the subdistrict center and open practices in their homes.

To overcome the shortage of health service workers in the *puskesmas* network, the local Health Department provided incentives by offering educational funds for health workers to continue their studies after completing their service contracts. The provisions of this educational fund vary in accordance to needs and availability of funds. This assistance is very important in addressing the problem that many of the medical personnel did not have accreditation that matched the specifications of their jobs.

Distribution and Quality of Health Workers

The critical shortage of healthcare workers in Central Lombok was made worse by the unequal distribution of their assignments.[3] The assignment of health workers at the *puskesmas* level is conducted by the Regional Personnel Board (BKD) of Central Lombok in coordination with the Health Department. The health workers are recruited by the BKD and assigned by the Health Department.[4] Currently, assignments have been oriented towards filling up specific positions without considering the educational backgrounds of the workers. As a result, there is an unequal distribution of personnel in terms of their qualifications. Of the 21 *puskesmas* in Central Lombok, only the Praya *puskesmas* has personnel whose educational qualifications fit their positions.

[3] Taqiudin, Kristiani , *Gambaran Ketenagaan Puskesmas dan Upaya Redistribusinya di Kabupaten Lombok Tengah Propinsi NTB.*

[4] *Ibid.*

The unequal distribution of healthcare workers also occurs in health service units that are in the *puskesmas* network, i.e., *pustu* and *polindes* (village maternity house). Ideally, the *pustu* has a *bidan*, a nurse, two administrative assistants, and one doctor or dentist. However, in reality, most of the *pustu* have only one nurse who handles all of the medical and administrative needs. Frequent requests from the *pustu* to the local Health Department for additional personnel generally do not receive a response. The head of the Gerunung *pustu* complained that:

> "We do not have enough health service workers at the *pustu* and I have already submitted a request to the *puskesmas* for more workers, but there haven't been any assignments yet. I still serve as the head of the *pustu*, the medical staff and the administrative staff."[5]

The distribution of *bidans* in the villages is also unequal. The problem is not just the unequal distribution, but also the lack of skill of the *bides* (village midwife) who cannot provide adequate childbirth assistance. In interviews with pregnant women, it was revealed that they felt that *bidans* were not as skilled as *dukuns* in assisting childbirth. *Bidans* only provide assistance during the birth of the child, cut the umbilical cord, then hand the patient back to the *dukun* or the family. Marnah relates the following:

> "I don't feel any difference between being assisted by a *dukun* or a *bidan* in childbirth. Once, one of my relatives gave birth and was attended by a *dukun*. She died. At that time, I became afraid of *dukuns*. But after I found out that she was already sick before she gave birth, then I wasn't afraid any more."[6]

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[5] Interview with the head of the Gerunung *Pustu*, August 14, 2007.

[6] Case study of Marnah, Praya village, August 19, 2007.

Although Marnah conceded that *bidans* had more equipment for assisting childbirth than *dukuns*, she admitted that she was not afraid of being attended by a *dukun*.

The quality of service of a *bidan* at the *polindes* and *puskesmas* is different from the service of a *bidan* who has a private practice. It is felt that a *bidan* provides more satisfying service and care in her private practice. The expensive fees set by the *bidan* in a private practice indicate the difference in quality of care. In Praya, the fees for a *bidan* in private practice range from Rp. 500,000 to Rp. 1,000,000. Meanwhile, at the *polindes* and *puskesmas*, although services for childbirth assistance are free, there are some *bidans* who charged for services because the reimbursement process by the government is very slow.

According to the *bidans*, PT Askes processes reimbursements for childbirth assistance every six months. Because of the delay in payments, the *bidans* have difficulties in covering daily operational expenses at the *puskesmas*. Transportation costs are included in the reimbursement payment, but they are limited to just Rp. 10,000 per case. *Bidans* do receive overtime pay for assisting a patient in the amount of Rp. 15,000 per day for five days. Although the amount is not much, it does help to cover operational expenses for *bidans*. Unfortunately, the payment for overtime is paid once every three months. This delayed system of payment makes it difficult for *bidans* to maintain their performance standards in providing quality service to the society, especially to women[7].

Availability of Health Workers and Health Services in Lebak

The district of Lebak suffers very serious shortages of health workers. Although there was a significant increase in the number of health work-

[7] As'ad, M. 2003. *Psikologi Industri*, Revised Edition, Yogyakarta: Liberty (Working Paper, No. 4, January 2006).

ers between 2004 and 2006 (see Table 3.4.),[8] Table 3.5. shows that in 2006 the shortage of health personnel in this district reached 82%.

Table 3.4.
Number of Medical Workers in Lebak

No.	Health Service Workers	2004[9]	2005	2006
1.	Doctor, general practitioner	57	69	88
2.	Dentist	19	8	22
3.	*Bidan*	199	187	208
4.	Nurse, general	185	232	232
5.	Nurse, dental	10	17	20
6.	Other health worker	38	272	272
	Total	**508**	**785**	**813**

Source: Health Service and Social Welfare Agency, Lebak, 2006.

Table 3.5.
Ideal Ratio, Availability and Shortage of Health Workers in Lebak

No.	Health Service Workers	Actual Number	Ideal Number	Shortage	Shortage (Percentage)
1.	Doctor, general practitioners	88	471	383	81.3
2.	Dentists	22	129	107	83.0
3.	*Bidans*	208	1,176	968	82.3
4.	Nurses, general & dental	252	1,382	1,130	81.8
	Total	**570**	**3,158**	**2,588**	**82**

Source: Health Service and Social Welfare Agency, Lebak, 2006.

Doctors availability

In 2005, there were 77 doctors in the district of Lebak – 69 general practitioners and eight dentists. In 2006, there were 33 more new doctors, bringing the total to 88 general practitioners and 22 dentists. They were spread throughout the subdistricts, averaging one to five doctors per subdistrict. There was only a slight increase in the number of nurses and *bidan* from 2004 to 2006, so the shortages remained high.

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[8] Based on data from *Rencana Strategis Kabupaten Lebak 2004-2009*, 2004.

[9] Based on data from *Data Pokok Pembangunan Kabupaten Lebak, 2005-2006*.

Bidans availability

Based on WRI findings, residents in Lebak tend to prefer a *bidan* to assist in childbirth rather than a doctor. The reason is that, as with the *dukun*, the villagers can ask the *bidan* to assist childbirth in their homes. However, the *bidan* faces many difficulties in assisting childbirth in villagers' homes. First, although the number of *bidans* in Lebak increased from 187 in 2005[10] to 208 in 2006,[11] it was still not enough to serve the health needs of the communities in 320 villages in Lebak. Second, the *bidan*'s practice and residence is often very far from the villagers' homes. Third, in addition to her duties at the *pustu*, the *bidan* or *bides* often opens a private practice in her own home far from the village, so she is not in the village after duty hours. For these reasons, many villagers ask a *dukun* to provide childbirth assistance. There are many *dukuns* in the area and they are easily accessible since most of them live in the villages. As a result, the percentage of births assisted by health workers in Lebak decreased from 56% in 2005 to 45.5% in 2006.

The *bidan* on duty at the *polindes*, West Sumba

[10] Based on data from the Health Services and Social Welfare Agency, Lebak, 2005.

[11] Based on an interview with the Head of the Health Services Sector.

Rahma

Pasir Tanjung Village, Rangkasbitung Subdistrict, District of Lebak

Rahma admitted that she often experienced difficulties when she was menstruating. She often suffered severe cramps as if in labor and felt extremely nauseous. Before she was married, her menstrual flows were very heavy, but after she married, her periods became very light.

Rahma also experienced health problems when she was pregnant and was sick for one month. When she went into labor for her first child, Rahma felt nauseous from early morning. Her husband called a *dukun*, but she could not save the baby. The delivery was difficult and took a long time since the baby was in a breech position. The baby's bottom came out first, and the baby couldn't breathe.

Rahma also experienced headaches and bleedings when she used contraceptive pills. Rahma switched to injections, but her menstrual periods became irregular and sometimes there was only a little bleeding that lasted for over one week. Before using the contraceptive injection, Rahma's menstrual periods lasted one week at the longest. She was never examined by a *bidan*. She did not consult a *dukun* or went to any other health service facility. She treated her health problems and discomforts only by drinking herbal drinks (*jamu*) or, sometimes, Sprite. Her friend told her about these treatments and she felt comfortable with them. She bought headache medicines at the nearby food stall. Because of the various problems she had with them, eventually Rahma decided not to use any kind of contraceptives.

During her pregnancy, Rahma usually went to the *bidan* at the *posyandu* for monthly regular examinations. However, entering into the fourth month of pregnancy, she started to also consult a *dukun*, which was a common practice in the village. Women who were pregnant less than four months were not allowed to be examined by a *dukun*, who massages the womb. According to a local myth, three-month-old fetuses are still in form of blood that should not be massaged.

Although she had heard and known about the Gakin program, which would waive a *bidan's* fees for childbirth assistance, Rahma choose to be assisted by *dukun* for her second pregnancy. She felt more comfortable

with the services of a *dukun* than a *bidan*. Rahma said that it was difficult to consult with a *bidan* about her reproductive health questions because there were no *bidans* living in her village. The *bides* on duty in her area lived in the town. She could consult the *bidan* only at the *posyandu* that was held once every month.

Since there was no *bidan* in her village, Rahma would have to go to the neighboring village or the closest town to consult a *bidan*, which was at least two kilometers away. Since there was no public transportation between the villages, she would have to hire a motorcycle taxi (*ojek*), which was very dangerous for a pregnant woman because the area was mountainous and the roads were very steep and slippery when it rained. Moreover, she would have to pass through forests and plantations, which were known to be unsafe since there were criminals there who would rob people, who were traveling through the area.

Posyandu Aides and Nurses availability

The other health service workers in Lebak when the field research was done in 2008 were the 6,142 *posyandu* aides, of which, only 3,450 were active. Based on data from the Health Services and Social Welfare Agency, there were 1,646 *posyandus* in Lebak, including 1,289 primary *posyandus*, 252 intermediate *posyandus*, 103 fully integrated *posyandus*, and 2 independent *posyandus*. Before they were hired and throughout their employment, the *posyandu* aides received various kinds of training concerning maternal and infant health, supplements for pregnancy, and 3T (problems of tardy diagnosis, tardy decision-making and tardy treatment), which often results in maternal and infant mortality.[12] They were also trained to record data on high-risk pregnant women and to make preparations for childbirth, including making arrangements for an ambulance. The aides also record the number of infants in the are who are considered

[12] Based on information from one of the *posyandu* aides in Cikarang, Lebak.

to be malnourished, provide them with food supplements, and encourage the mothers to make routine check-ups at the *posyandu*. The aides are not, however, trained in assisting childbirth.

Other than *posyandu* aides, general and dental nurses also provide significant assistance to the community. The total number of nurses in Lebak increased from 195 in 2004 to 252 in 2006. The nurses in this area had different educational backgrounds. Most of them were graduates of the Midwife Education School (SPK) holding a D1 certificate, while other nurses had D3 nursing certificates, and a few of them had undergraduate degrees in nursing. In Lebak, nurses usually open private practices to provide health services and are available for home visits to patients for simple or common illnesses, such as stomach aches, headaches, muscle pains, toothaches, skin rashes or allergies, diarrhea, fever, coughs, inflenza, respiratory infections, and first aid for minor accidents. Only female nurses may assist in childbirth in the hospital in Lebak because they have received appropriate training. There is a serious shortage of nurses, which approaches almost 82% of the ideal number needed by the community.

Availability of Health Workers and Health Services in Jembrana

The shortage of health workers in Jembrana is the smallest in comparison to shortages in the other districts. Table 3.6. shows that the shortages of general practitioners and *bidans* in 2006 were 27% and 47% respectively, which were lower than the shortages in the city of Surakarta in the same year, which came to 35% and 60%. The Jembrana Health Insurance (JKJ), the health insurance system for all Jembrana residents, and the regulations regarding the practices and quality of *bidan*'s services contributed to the better supply of health service workers in this district. The majority of doctors and *bidans* in Jembrana participate in the JKJ scheme.

Table 3.6.
Ideal Ratio, Availability and Shortage of Health Workers in Jembrana

No.	Health Service Workers	Actual Number	Ideal Number	Shortage	Shortage (Percentage)
1.	Doctor, specialist	9	15	6	41
2.	Doctor, general practitioner	74	101	27	27
3.	Dentist	15	28	13	46
4.	*Bidan*	134	253	119	47
5.	Nurse, general & dental	217	298	81	27
	Total Nakes	**449**	**696**	**247**	**35**

Source: Health Services and Social Welfare Agency of Jembrana, 2005.
Total population: 253,403.

Doctors availability

Jembrana's uniqueness amongst the other research areas lies in the fact that most of the doctors in the district are registered as service providers in the JKJ program. All of the doctors in the district, except five of them – three general practitioners and two dentists, – treated patients who were covered by the JKJ policies.[13] There were 78 doctors who provided services for JKJ patients in 2005, including 5 in Melaya subdistrict, 51 in Negara subdistrict, 14 in Mendoyo subdistrict, and 8 in Pekutatan subdistrict.[14]

If we just look at the number of villages and doctors in Jembrana, it would appear that the number of doctors available already fulfills the need for medical expertise in the district. However, in reality, the doctors were not evenly distributed throughout the villages.They were concentrated in strategic areas, i.e., the urban centers. Most of the general practitioners were on duty at the public hospitals, private hospitals, clinics, *puskesmas*, and *pustus* in the mornings and opened private practices in the evenings from 5 p.m. to 9 p.m.

[13] Based on an interview with the Head of the Health Services of the Health and Social Welfare Agency, Jembrana. This data can also be seen in *Jembrana dalam Angka, 2006*.
[14] BPS, 2006. *Jembrana dalam Angka, 2006*, p. 146.

The doctors charged between Rp. 15,000 to Rp. 50,000 for their services. The fee for handling reproductive health cases, such as abnormal vaginal discharges, was between Rp. 20,000 to Rp. 30,000. However, patients who were JKJ participants received treatments for free. The Regional Social Security Provider pays pre-established fees for health services for JKJ participants.

Nurses availability

There were 195 general nurses and 22 dental nurses in Jembrana in 2005.[15] Similar to the situation with the doctors, there were actually sufficient numbers of nurses to serve all villages in the district. However, in reality, the nurses were not evenly distributed and some villages did not have any nurse at all.

Nurses in the district provide the same health services as *bidans*, i.e., providing treatments for light illnesses. Unlike *bidans*, nurses do not provide any services related to reproductive health, family planning, and maternal health. Nurses usually open their own practices to provide health services for patients. If a patient is unable to go to the practice, then the nurse is willing to provide care in the patient's home.

Nurses' consultation hours vary. Some open their practices in the evening from 5 p.m. to 8 p.m., but others open their offices both in the morning and evening. The fees charged ranged from Rp. 7,000 to Rp. 25,000 for all patients, both JKJ participants and non-participants. People chose to consult nurses because they were familiar with them, they were close, the fees were inexpensive, and their treatments seemed to work.

[15] Based on data from the Health and Social Welfare Agency, Jembrana, 2005. The total includes nurses with certificates and undergraduate degrees.

Bidans availability

In 2005, there were 134 *bidans* in Jembrana.[16] This total increased to 160 in 2010.[17] In terms of quantity, the number of *bidans* in Jembana exceeds the total number of villages in the district, which is 52. However, as with the doctors and nurses, the distribution of *bidans* is not equal, so some villages do not have any *bidans* in residence or who have a practice there. Some *bidans* worked for the government in the *puskesmas* network and some others have their own private practices. Some of them have D3 nursing certificates.

Procuring a license to open a private practice in Jembrana is easy. A *bidan* said that the government did not make it difficult for *bidans* to obtain a license. They only have to register, pay the administration fees and wait for the decision. There are no other fees involved for securing a license. *Bidans* do not have to pay fees when they move their practice to another area.[18] In order to obtain a license for a private practice, a *bidan* must have a license to store medicine (SIMO), which states that the *bidan* has standard medicines and equipment available. If any unregistered medicines are found in the practice, then the *bidan* will receive a warning and her license could be revoked.

A *bidan* in Jembrana must have a Normal Childbirth Training certificate (APN). Without this certificate, they are not allowed to open a private practice. Those who established their practices before this certificate was required are advised to immediately enroll in the APN training. In addition to this, the *bidan* must also have a certificate for emergency childbirth care and have participated in the Clinic Performance Management Training (PMKK).[19] In this training, the *bidan* studies various stardard procedures in providing healthcare, including administering vaccinations,

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[16] Based on data from the Health and Social Welfare Agency, Jembrana, 2005

[17] Based on an interview with the Head of the Health Services.

[18] Based on an interview with a *bidan* in Candikusama Village.

[19] Based on an interview with a *bidan* in Melaya Village.

standard childbirth assistance, etc. All *bidans* in Jembrana sign contracts with the Regional Social Security Provider and they provide health services to JKJ patients.

Table 3.7.
Number of *Bidans* in Health Facilities in the district of Jembrana

No.	Work Unit	Number of Medical Personnel		
		***Bidan* with Certificates**	***Bidan***	**Total**
1.	*Puskesmas*, including *Pustu*	18	52	70
2.	Regional Public Hospitals	11	22	33
3.	District Health Service Agency	2	0	2
4.	Praja Husada Hospital, Gilimanuk	0	4	4
5.	Darma Sentana Hospital	0	5	5
6.	Kerta Yasa Maternity Hospital	2	4	6
7.	Other Health Facilities	0	14	14
	Total	33	101	134

Source: Health and Social Welfare Agency, Jembrana, 2005.

Health service facility at the *polindes*, West Sumba

Ida Ayu
Tegal Badeng Timur Village, Negara Subdistrict,
District of Jembrana

Difficulty in Finding Medical Personnel

Ida Ayu often experienced problems when she was menstruating, had unusual vaginal discharges, suffered complications during pregnancy and childbirth, and while using contraceptives. She suffered extreme cramps, felt weak and faintness during the first three or four days of menstruation. This condition continued after she was married. Her periods were irregular and very painful. In her last menstruation, she experienced more bleeding than usual.

She also experienced problems during her pregnancies. She was 16 when she got pregnant for the first time, and 19 when she became pregnant the second time. Her pregnancies were classified as high-risk since the first one lasted for 10 months and the second one for 11 months. During the second pregnancy, Ida Ayu suffered complications and she developed very high fever. She also had problems during childbirth. She first gave birth when she was 17 years old. When she gave birth to her second child, she felt nauseous for more than 24 hours. After giving birth, Ida Ayu suffered heavy bleeding and fainted.

Later, when she used the three-month contraceptive injection, her weight increased drastically and she suffered minor bleeding and extreme abdominal pain for one month. Ida Ayu then changed her contraception to a one-month injection, but the problems continued and her breast milk dried up. Then she switched to contraceptive pills while still nursing. The pills, however, gave her headaches.

Ida Ayu always treated her pain during menstruation and discomfort from vaginal discharges with traditional herbal drinks made from tumeric and tamarind. She did not want to consult a *bidan* or a doctor because there were none in her village and she would have to hire an *ojek* to go to the neighboring village. The *ojek* would have cost her a lot of money at a time when she had limited resources.

During her first pregnancy, Ida Ayu consulted a *bidan* for regular check-ups because her pregnancy was considered to be high-risk. Besides following the *bidan*'s advice, Ida Ayu also consumed herbal drinks (*jamu*) that her neighbors and the *jamu* vendor recommended. They said that the *jamu* would help her to recover after giving birth.

Although she was a JKJ participant, Ida Ayu chose to give birth at home and to be assisted by a *dukun*. She was afraid to ask a *bidan* for help. She was traumatized by her sister-in-law's bad experience with a *bidan* when she gave birth. At that time, the *bidan* who helped her sister-in-law got angry. When her sister-in-law was in pain, the *bidan* just ignored her and told her to wait even though she was suffering. Finally, she left the *bidans* house, went home on an *ojek*, and then gave birth at home with the help of a *dukun*. For Ida Ayu, delivering at home was cheaper, and she felt comfortable being assisted by a *dukun* because the *dukun* was friendly and she came to her house. The *dukun* made her feel more comfortable and calm.

Ida also suspected that JKJ card holders were treated differently than patients who did not have a JKJ card. She felt that when she used the JKJ card, the treatment that she received did not help her to recover from the illness. When she did not use the JKJ card, she recovered more quickly. Several of her neighbors said the same thing. Ida suspected that the medicines that are given to patients with JKJ cards are not as good as the medicines given to patients without JKJ cards.

The fees charged by the *bidan* for health services vary depending on the kind of service provided. Routine pregnancy exams cost about Rp. 20,000, while the fee for childbirth assistance is between Rp. 400,000 to Rp. 600,000. However, for difficult deliveries, the fee could be as much as Rp. 1,000,000. Fees for childbirth assistance are charged to all women, including those who use the JKJ card. The *bidan* also provides family planning services, including all methods of contraception, except sterilizations, vasectomies, condoms, and diaphragms. The cost for implants ranges from Rp. 150,000 to Rp. 250,000. The cost of an IUD ranges from Rp. 75,000 to Rp. 150,000, while patients pay Rp. 15,000 for pills and

injections. These charges are based on the fees set by the Regional Social Security Provider. The *bidan* will also provide services related to reproductive health, however serious cases, are referred to a specialist.

These charges are not the same for patients who are participants in the JKJ program. JKJ cardholders are not charged for the use of contraceptive pills or injections, but they are charged for IUDs and implants. They are, however, not charged the regular Rp. 20,000 fee for examinations of infants and children. *Bidans* also provide health services for common illnesses, such as fevers, coughs, influenza, headaches, toothaches, and abdominal pain. The fees for these consultations range from Rp. 7,000 to Rp. 25,000 for patients who are not JKJ cardholders. The JKJ participants are not charged for these consultations.

The JKJ system and regulations on the licensing of practices that guarantees the quality of *bidans* services, have had a positive impact on the availability of *bidans* in the district. Between 2006 and 2010, the number of *bidans* in Jembrana increased by almost 20%.

Availability of Health Workers and Health Services in Surakarta

Surakarta is the only research area where there was a surplus of health workers, especially nurses who exceeded the ideal ratio number (142%). However, there was still a shortage of general practitioners (35%) and a serious shortage of *bidans* (60%).

Table 3.8.
Ideal Ratio, Availability and Shortage of Health Workers in Surakarta

No.	Health Service Workers	Actual Number	Ideal Number	Shortage	Shortage (Percentage)
1.	Doctor, general practitioner	138	214	76	35
2.	*Bidan*	216	535	319	60
3.	Nurse, general & dental	1.521	628	(893)	(142)
	Total	**1.875**	**1.377**	**(498)**	**(36)**

Source: Health Profile, Surakarta, 2007, Health Services Agency

Doctors availability

In 2007, there was a 35% shortage of doctors in Surakarta. The shortage of doctors was made worse by the imbalance between the number of doctors working for public health services and those running private practices. Table 3.9. shows that of the 659 doctors in the city, more than 95% had private practices. Public health services, such as *puskesmas*, *pustu*, and *pusling,* experienced serious shortages of health workers, specifically doctors. Table 3.10. provides an example of the shortages in two *puskesmas* units in the research area. The Sangkrah *puskesmas* is a public health facility in the Pasar Kliwon subdistrict that services three wards – Sangkrah, Semanggi and Kedung Lumbu – with a total population of over 78,598.[20] This means that each of the three doctors on duty, assisted by five nurses and six *bidans*, must provide services to approximately 26,199 residents.

The Gilingan *puskesmas* is a public health facility in the subdistrict of Banjarsari that services three wards – Gilingan, Kestalan and Punggawan

Table 3.9.
Number of Health Workers in Surakarta, 2004

No.	Health Service Worker	Public Work Unit	Private Work Unit
1.	Doctor	32	627
2.	Dentist	23	37
3.	Nurse	96	1,108
4.	Nurse, undergraduate degree	-	13
5.	*Bidan*	90	143
6.	Pharmacy Aide	37	136
7.	Pharmacist	3	13
8.	Sanitary Expert	27	-
9.	Community Health Expert	8	-
10.	Nutritionist	11	58
11.	Physical Therapist	-	48
12.	Medical Technician	13	60
13.	Other	269	-

[20] Total population in Pasar Kliwon subdistrict, based on data from Health Profile, Surakarta, 2006.

– with a total population of 159,314.[21] This means that each of the three doctors at the *puskesmas*, assisted by five nurses and 5 *bidans*, must serve 53,104 people. One can imagine the doctors' burdens if all of the residents rely on the *puskesmas* for treatments. The situation was further complicated by the fact that only one of the three doctors on duty at this *puskesmas* was a general practitioner, while the other two were dentists.

Table 3.10.
Number of Health Workers in *Puskesmas* in WRI Research Area, 2006

Work Unit	Health Worker								
	Doctor	Nurse	*Bidan*	Pharmacist	Nutritionist	Medical Tech	Sanitation	Comm Health	Total
Sangkrah Puskesmas	3	5	66	2	1	1	1	0	19
Gilingan Puskesmas	3	5	55	3	1	0	2	0	19

Quality and Service of Health Workers

Usually there is only one, or possibly two, general practitioner on duty at the *puskesmas*, and there are no specialists. The nurses and *bidans* who assist in providing health services have different levels of education and expertise. Some nurses have graduated with a D3 certificate, however, most of them have D1 level education. Patients that require a specialist must be referred to a hospital, either public or private, that have proper medical equipment and expertise to handle difficult cases.

Recently, several *puskesmas* units in Surakarta developed a cooperative program with large hospitals to bring specialists, particularly pediatricians and gynaecologists, to the *puskesmas* once a month to provide consultations and treatment. However, this cooperative program was not easy to implement because of the difficulty in scheduling specialists who have full schedules and usually prioritize their work at the hospitals. Patients at the *puskesmas* were often disappointed because they could not

[21] Total population in Banjarsari subdistrict, based on data from Health Profile, Surakarta, 2006.

consult with the doctors as promised. Also, the once-a-month visits by specialists were felt to be inadequate to meet the needs of the patients at the *puskesmas*.

The insufficient availability of general practitioners and specialists at public health facilities, such as the *puskesmas*, shows that the government faces serious problems in providing affordable and quality healthcare services to the public. The head of the Gilingan *puskesmas*, who is a dentist, said that it is not easy to address the variety of needs of the public with the limited staff at the *puskesmas*.[22] One general practitioner is not enough to provide treatment for all of the patients who go to the *puskesmas* for treatment, which on the average reaches 70 people per day. Moreover, the *puskesmas* also has other health service programs for the outlying communities, including the *pustu*, *pusling*, health information dissemination, school visits to school health units (UKS), and assistance for the routine *posyandu* in each of the wards in the area.

The head of the Sangkrah *puskesmas* faces similar problems.[23] In addition to routine treatments, the *puskesmas* also runs an sexually transmitted diseases (STD) Clinic that needs doctors in attendance.

> "Sometimes we have to rush from one place to the other to treat patients. Patients that have sexually transmitted diseases must be referred to the STD Clinic, but there are no doctors there since they are treating patients in the *puskesmas*. So the doctors must divide their time between the patients in the *puskesmas* and the STD Clinic."

The presence of nurses and *bidans* is very important. Because doctors are rarely available, the *bidans* or nurses who are on duty often have to treat patients at the *puskesmas*, even though they are not supposed to because they do not have the required educational background.

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[22] Interview with Dr. Sri Harnani, Head of Gilingan *puskesmas*, August 13 and 15, 2007.
[23] Interview with Dr. Maria Retno S., Head of Sangkrah *puskesmas*, August 8, 2007.

Bidan and Nurses

As previously discussed, in 2006, there were 1,919 *bidans* serving a population of 512,898 in Surakarta. Most of these *bidans* were assigned to work in the hospitals (53.1%), while the rest (31.9%) worked in the *puskesmas* network, including *pustu* and *polindes*. *Bidans* treated mothers and children, while nurses provided advanced care to patients under consultation and supervision of doctors. A nurse is not trained to diagnose illnesses or to treat patients. However, in practice, a *bidan* often performs the same functions as a doctor, both at the *puskesmas* and in her private practice.

In the Semanggi area, there was a nurse who served at the *puskesmas* as a doctor, and she examined and treated HIV positive patients. Nurse Nanik[24] was assigned to work at the Punggawan *puskesmas* and lived in the government doctor's house in the Semanggi ward. She also had a private practice in her home to provide healthcare services to the Semanggi residents. Nurse Nanik was able to live in the doctor's house because no doctors were willing to live there in Silir, which was formerly a prostitution area that was plagued by crimes and health problems, especially sexually transmitted diseases. Nurse Nanik treated a wide variety of illnesses, but she did not provide assistance in childbirth, even though many patients had requested it. She admitted that she had acted beyond her mandate as a nurse. Patients came to her because the practice was easily accessible and they were confident that Nanik could treat their illnesses.

Bidans at the *puskesmas*, whose primary tasks are to deliver babies, administer immunizations and examine pregnant women and infants, also face similar predicaments. They treat patients as a doctor would both at the *puskesmas* and in their private practices. Indeed, there are some *bidans* who have been granted a limited authority to act as a doctor after they acquired specific training and education. There are several kinds of education for a *bidan*: Midwife Education School (SPK) that is at the same

[24] Based on an interview with a respondent in the Semanggi ward, Pasar Kliwon, August 16, 2007.

level as a high school and has a four-year curriculum, a one-year D1 certificate program for high school graduates, and a three-year D3 diploma program that is also open to high school graduates. Graduates of any of these programs may open a practice after taking an exam provided by the Indonesian *Bidan* Association (IBI) and received a license to practice from the Health Department. The license to open a practice costs Rp. 150,000, and it needs to be renewed every five years.[25] To attain the certificate for a *Delima Bidan*, who has the authority to act as a doctor in extenuating circumstances if a doctor is not present, the *bidan* must obtain a D3 education that costs at least Rp. 2,000,000. Because of that, many *bidans* can not afford to apply for and finish the D3 course.

According to one *bidan* who has a *Delima Bidan* certificate, in reality there are many *bidans* who open private practices without having proper certification and license.[26] They are usually new graduates who have attended nursing school. To get a license, a *bidan* must undergo a competency test administered by IBI to determine if she has the knowledge and skills to run a private practice. Usually it takes six months for the Health Department to issue a license. Several *bidans* complained about the lengthy process. They were worried that an inspector from the Health Department might inspect their practice before the license was issued. A request to renew an existing license in Surakarta must be submitted three months before the expiration date. The system of providing licenses in Jembrana is much easier. To open a practice, a *bidan* needs only to pay an administration fee. The easy and inexpensive licensing process in Jembrana contributes to the fact that their shortage of *bidans* was only 47%, while it was 60% in Surakarta.

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[25] Based on regulation in Regional Regulation No. 4/2007 concerning Retributions for Equipment and Labor Licensing in the Health Sector, Surakarta. The section of this regulation regarding the fee for licensing for a *bidan*'s practice was revised from the previous fee of IDR 300,000.

[26] Based on an interview with *Delima Bidan* Lestari Anggraeni, who has a practice in Gilingan, August 13, 2007.

Wulansari

Sangkrah Ward, Pasar Kliwon Subdistrict, Surakarta

Wulan is the youngest of six children and has an elementary school education. When she was 18, she married Basuki, who also has an elementary school education. Wulansari's husband worked as a parking attendent at a clothing store and he did not have a fixed income. Wulansari sold vegetables. Although they both worked, their combined income was less than Rp. 600,000 per month, making them eligible to become Askeskin cardholders.

By the time she was 35 years old Wulansari had six children. Her youngest daughter is now 15 months old. Wulansari admitted that she did not want to have any more children, and she is now using contraceptives. After giving birth to her second child, Wulansari had contraceptive injections administered at the Sangkrah *puskesmas*, where she paid Rp. 4,000 for an injection every month. The injections made her menstrual cycle become irregular. She asked the *bidan* at the *puskesmas* about this, but since her condition did not improve, she decided to stop the treatment. Not long after this, she became pregnant with her third child. After the birth, a *bidan* told her to use an IUD, but did not provide any explanation regarding the risks involved. She paid Rp. 10,000 for a doctor to insert an IUD.

The IUD created several side effects, such as heavy and lengthy bleeding and extreme pain during menstruation. She also felt heat and pain in her vaginal area and suffered abdominal cramps. Wulansari often complained to the *puskesmas,* but there was no improvement in her condition. After five years, she decided to have the IUD removed and switched to a contraceptive injection that she received at the *puskesmas* for free because she was an Askeskin cardholder.

A fourth pregnancy could not be avoided. After giving birth to her fourth child, she decided to participate in the sterilization program, promoted by the Family Planning Board that cost Rp. 60,000 for a tubectomy that was to be performed at the public hospital in Jebres. This fee was considered to be inexpensive in comparison to the fees charged at the hospital that ranged from Rp. 500,000 to Rp. 700,000.

Prior to the operation, Wulansari was advised to fast for one day and not to drink coffee. Joined by three other women who also wanted to be sterilized, Wulansari admitted that she did not really understand what the doctor was going to do in the operation. She only believed that by being sterilized she would no longer be able to become pregnant. The operation began at 11 a.m. Although the other three women who had undergone the same operation had regained consciousness and gone home, Wulansari still had not regained consciousness by 8 p.m. Her husband and family became worried. Basuki went to the hospital to inquire about his wife's condition. He had not given permission for Wulansari to have the operation and had refused to sign the agreement form. Her father also refused to sign the form because he was afraid that the operation would fail. However, Wulansari was determined to undergo the operation without her husband's and her parents' permission. She went to the hospital with the *bidan* from the local *puskesmas*. Basuki was shocked and angry that Wulansari had not regained consciousness after the operation.

The health workers explained that it was difficult for Wulansari to regain consciousness because she had been anesthesized more than once. According to the doctor, even after the first dose of anesthesics Wulansari could still feel the pain and she was screaming during the operation. Because of this, the doctor gave her a second dose of anesthesics. However, the effects of the second dose were so strong that she remained unconscious for a long time. When her heartbeat stopped, the doctors rushed her to the Intensive Care Unit. Wulansari almost died. After regaining consciousness, she said that when her heart began beating again, she could hear voices around her, but she was too weak to respond.

The operation that almost cost Wulansari her life failed because she became pregnant for the fifth time six months after the operation. She complained about this post-sterilization pregnancy to the Jebres Hospital where the operation took place, but they did not have a policy for handling cases of failed contraception. The medical workers at the Sangkrah *puskesmas* refused to treat her when she wanted to use contraceptives again. She was forced to go to a doctor and pay Rp. 75,000 to have an IUD inserted, which she felt was very expensive because previously she had received free family planning service with her Askeskin card at the *puskesmas*.

Availability of Health Workers and Health Services in Indramayu

Indramayu and Lebak are the two research areas that had the most serious shortages of health workers, i.e., 82%. Table 3.11. shows that the availability of health workers in Indramayu in 2006 was still very far from the ideal standard for 2010 in accordance to the Minimal Service Standards (SPM) in the health sector. The data collected by WRI indicates that many people, both male and female, buy medicine in a pharmacy or food stall to treat themselves. Although consultation with a doctor and a *bidan* are still popular choices, more people buy medicine for self-treatment. There are two conclusions that can be drawn from this. First, people do not consult healthcare workers because there are not enough of them, and second, people are not aware of the advantages of consulting healthcare workers.

Table 3.11.
Ideal Ratio, Availability and Shortage of Health Workers in Indramayu

No.	Health Service Workers	Actual Number	Ideal Number	Shortage	Shortage (Percentage)
1.	Nurse	894	2,008	1,114	55.5
2.	*Bidan*	456	1,709	1,253	73.3
3.	Doctor, specialist	13	103	90	87.4
4.	Doctor, general practitioner	91	684	593	86.7
5.	Dentist	34	188	154	82
	Total	**1,488**	**978,717**	**839,367**	**82**

Source: Personnel report, district of Indramayu, 2006. Population: 1,709,128 people

In addition to the shortage of health workers, there is again a problem of uneven distribution of the health service personnel in Indramayu. There were 69 general practitioners assigned to 49 *puskesmas* in the district. Nine *puskesmas* had 2 doctors, 4 *puskesmas* had 3 doctors, only 2 *puskesmas* had 4 doctors, and each of the rest of the 34 *puskesmas* had only 1 doctor. Two *puskesmas* do not have any doctors or dentists on duty.

Table 3.12.
Availability of Health Workers in Indramayu

No.	Personnel	Institution				Total	Population	Ratio/100,000 People		Need	Shortage
		Puskesmas	Public Hospital	Private Hospital	Health Service			2006	Ideal		
1.	Nurse	642	74	167	11	894	1.709.128	52,31	117,5	2.008	1.114
2.	*Bidan*	402	20	26	8	456	1.709.128	26,68	100	1.709	1.253
3.	Pharmacy	8	9	13	4	34	1.709.128	1,99	10	171	137
4.	Nutrition	32	2	4	7	45	1.709.128	2,63	22	376	331
5.	Sanitation	34	0	3	17	54	1.709.128	3,16	40	684	630
6.	Comm Health	9	1	5	11	26	1.709.128	1,52	40	684	658
7.	Dokter Sp	-	12	1	-	13	1.709.128	0,76	6	103	90
8.	Doctor, gp	68	14	3	6	91	1.709.128	5,32	40	684	593
9.	Dentist	28	2	3	1	34	1.709.128	1,99	11	188	154

In general, people consult doctors at the *puskesmas* or their private practices if the *bidan* can no longer treat their illness. Several doctors live at or near the *puskesmas* they are assigned to in Indramayu. The doctors

are on duty at the *puskesmas* between 8 a.m. to 12 noon and open their private practices after those hours. One doctor spoke about the system of payment for services:

> "We treat emergency cases outside of office hours because we live at the *puskesmas* and provide first aid. If they offer us payment, then we accept it. If further medical care is needed, the doctor refers the patient to Basic Obstetric and Neonatal Emergency Care (PONED) or the hospital."

Doctor Bintang, who practiced at the Kandanghaur *puskesmas* did not have a private practice at his home and he was always available when needed at the *puskesmas*. At first, he tried to open a practice in his home, but since he was often called to the *puskesmas* to handle emergency cases outside his regular on-duty hours, he had difficulty setting time aside for the patients in his private practice. Ideally, the doctor occupies a functional position at the *puskesmas* treating patients, while a community health specialist (SKM) occupies a structural position that deals with administrative tasks thus allowing the doctor to concentrate on providing medical treatments.

Bidans availability

The primary duty and function of the *bides*, as specified in Executive Letter No. 429/Binkesmas/DJ/89 of the Community Health Sector of the Health Department, is to improve the quality and service of maternal and child health (KIA) and family planning to reduce the number of maternal and infant fatalities in childbirth. It is, thus, necessary to examine how the services of the *bidan* fulfill these roles and functions.

In 2005, there were 416 *bidans* in Indramayu. The following year, the number increased to 456 *bidans*. Of this total number, 378 *bidans* were assigned to work in the *puskesmas* network, 26 at Indramayu Public Hospital, 4 at Pertamina Balongan Hospital, and 1 at Zam-Zam Jatibarang

Hospital. Seven other *bidans* worked at the Health Department in the Indramayu district office. The actual number of *bidans* in Indramayu was 73.3% of the ideal number. Besides the shortage of *bidans*, their distribution throughout the district was uneven. Some *puskesmas* units had only two *bidans* on duty, while others had more than ten. The *puskesmas* units served as many as 3 to 13 villages. This means that the *puskesmas* units that had only two *bidans* had difficulties in assigning them to the villages in their area. For example, Kertawinangun *puskesmas* only had two *bidans* to handle five villages, while Kertasemaya *puskesmas* had 15 *bidans* to serve 13 villages.

The distribution of *bidans* was uneven because their assignments to the *puskesmas* were not based on the number of villages in the work area of that *puskesmas*. In addition to this, many of the *bidans* who were assigned to specific villages (*bides*) do not reside in that village, but rather live in the urban areas. WRI observed that many cities and towns had a sufficient number of *bidan*. In the Indramayu urban subdistrict it is very easy to find three or four private *bidan* practices in relatively close proximity. However, in rural subdistricts there might be only one *bidan* to serve an entire subdistrict. If the *bides* does not live in the village, then the villagers must go to the closest town that has a private *bidan* practice.

Many *bides* do not reside in the area they are assigned to work in because not all of the villages have Village Maternity House (*polindes*) facilities where a *bides* can reside and provide healthcare services. There are only 20 *polindes* in Indramayu. According to Bidan Yetty in Pekandangan Jaya, only two of the 20 *polindes* function as they should. The rest are not in use because of inadequate equipment and infrastructure. As a result, according to one informant who lived far from the *puskesmas* and *pustu*, one mother who had gone to a *bidan* for her pregnancy examinations later asked a *dukun* for help when she gave birth because the *bidan* who examined her was not available to help deliver the baby.

It is also important to view the quality of the services provided by *bidans*. Of the 378 *bidans* assigned to the *puskesmas* network in 2005, approximately 85% were graduates of basic *bidan* education with D1 cer-

tificates and only 15% fulfilled competency requirements expected of a D3 *bidan* diploma. The educational background of *bidans* affects the quality of the service they provide. Based on WRI's survey in Indramayu, health workers in this district were amongst those who provided the least amount of information about health to the community. Only 27.3% of the respondents received information about possible complications during pregnancy, childbirth and recuperation. This was the lowest percentage compared to the six other WRI research areas and far below that of Surakarta, where 60.7% of the respondents received information about reproductive health.

In an effort to broaden community access to health facilities and services, the Indramayu government initiated a policy of free service for basic healthcare at the *puskesmas* and *pustu*. However, the implementation of this policy affected the workload of the health workers. According to the data from the Health Department, the number of patient visits to the *puskesmas* increased by 50% since the introduction of the policy. The health workers at the *puskesmas* had to work extra hard to treat all of the patients and this, of course, had an effect on the quality of the healthcare provided. Interviewees indicated that they had to wait for a long time for treatment at the *puskesmas*. Thus, people who could not afford private treatment, had to accept the long wait for healthcare service at the *puskesmas*.

Availability of Health Workers and Health Services in North Lampung

In 2006, the shortage of healthcare workers in North Lampung was 67%, approximately the same as the shortages in Central Lombok (66.6%) and West Sumba (62.3%). Although the shortage was not as serious as that of Indramayu and Lebak (both 82%), North Lampung was far behind Jembrana, which had a shortage of healthcare workers of only 35%.

Table 3.13.
Ideal Ratio, Availability and Shortage of Health Workers in North Lampung

No.	Health Service Workers	Actual Number	Ideal Number	Shortage	Shortage (Percentage)
1.	Doctor, specialist	7	34	27	79
2.	Doctor, general practitioner	44	224	180	80
3.	Dentist	20	62	42	68
4.	*Bidan*	167	561	394	70
5.	Nurse, general & dental	264	662	398	60
	Total	**502**	**1,543**	**1,041**	**67**

Source: *Health Profile, North Lampung, 2006*, issued by the Health Services Agency

Doctors availability

Table 3.13. shows that in 2006, there were 71 doctors and dentists in North Lampung, including 44 general practitioners, 7 specialists and 20 dentists.[27] One general practitioner was assigned to work at the Health Department in the North Lampung district office, while 33 doctors worked in the *puskesmas* network and 10 doctors were on duty in the hospitals. One of the reasons for the shortage of doctors in North Lampung was that some doctors had been transferred to other districts and there had not yet been new assignments to replace them, affecting the delivery of health service to communities. Although they are mandated to assist only in childbirth, contraceptive use and immunizations, in the absence of a general practitioner and a specialist, a *bidan* or nurse at the *puskesmas* is forced to provide healthcare services that should be provided by a doctor.

Location of the *Bidan*

According to the Health Department of North Lampung, here were 284 *bidans* in the district in 2010. This was an increase from 167 in 2006. The *bidans* were assigned to hospitals, *puskesmas*, *pustu*, *pusling*, and *polindes*. In general, they also ran their own practices in their homes.

[27] Based on data from *Health Profile, North Lampung, 2006*, issued by the Health Service Agency.

A minimum of three *bidans* are assigned to each health facility to assist doctors and nurses in providing healthcare. Recently graduated *bidans* were assigned to serve as *bides* at the *pustu* or *polindes* and were responsible for providing healthcare to mothers and children in one village. However, it is very rare to find a *bides* who resides at the *polindes* and is on-call for 24 hours. The *bidans* are on duty at the health facility from 8 a.m. to 1 p.m., after which they return to their homes where open their private practices.

Education and Services Provided by *Bidan*

Most of the 284 *bidans* in North Lampung in 2010 had D1 certificates (242 *bidans*, 85%). Only 42 *bidans* (15%) had D3 diplomas. The national standards for *bidans* determined that in 2010, a practicing *bidan* must have at least a D3 diploma and it is hoped that they continue their education for a D4 diploma. In view of the fact that a *bidan* is often asked to substitute for a doctor, it is unfortunate that this policy is not accompanied with a provision of financial assistance for *bidans* who need to further their education.

Purwati
(Hanakau Jaya Village, North Lampung Subdistrict)

"The Availability of Limited Healthcare Facilities"

Purwati is a 32-year old mother of two. She has an elementary school education and her husband, Paturoni, has never been to school. Paturoni is a laborer who will take any job he is offered. This means that he does not have a permanent job that can provide a routine monthly income, while Purwati is a housewife. Their monthly income is approximately Rp. 600,000.

Purwati and Paturoni lived with Purwati's parents in a small house that is 20 m² (5 x 4 m). Six people live in this house that is owned by Purwati's parents. They get their clean water from a public well that is 15 minutes away from their house. The family does not yet have an adequate bathroom, so for personal needs, they use a hole dug in the earth in the back of their house. At present, Purwati and her family are registered as Askeskin cardholders. They received the cards after officials visited their home and registered them.

Purwati has two children, the youngest one was two years old, and she was pregnant with her third child. Purwati prefered to treat herselft with traditional methods. For example, she drank *jamu* to treat discomfort during menstruation, childbirth and recuperation, so she rarely went to health facilities. She has never been immunized for tetanus in any of her pregnancies, and her youngest child had never been immunized. Purwati did not understand the importance of immunizations for infants and children. When experiencing discomfort in her reproductive organs, such as irritation in her vaginal area, pain during intercourse, and cramps in the lower abdomen, she consulted a *dukun* for treatment. The *dukun* lived close to her house and was relatively inexpensive (Rp. 5,000). Throughout her pregnancies and when she experienced a miscarriage, she was treated by the same *dukun*. For the delivery of her last chid, Purwati paid the *dukun* Rp. 150,000, which was much cheaper than going to a health facility.

Purwati lives in Hanakau Jaya Village, far from the city center in North Lampung. The infrastructure in Hanakau is limited. To reach Hanakau Jaya, one must pass 15 kilometers of oil palm and cassava plantations. It takes about two hours by bus to get to the city center of Kotabumi. The main road was badly damaged, full of holes, rocky, and several portions were dangerously muddy and very slippery. These conditions were made worse because there are criminals that often attack people on the road and steal their motor vehicles. Transportation is very limited. There is only one public bus that passed by in the morning and in the evening. The other choices for transportation are private vehicle or *ojek*. Purwati said that her husband has been dominant in making the family decisions, including choice of health treatment, assistance for childbirth, and transportation used when accessing treatment when sick.

There is only one *pustu* in this village that is open for service every Monday through Saturday, from 8 a.m. to 12 noon. There is only one nurse on duty who also serves as the head of the *pustu*. The villagers of Hanakau Jaya usually ask the *dukun* in their village to assist childbirth. Only a small minority chooses to access the healthcare services of a *bidan* or *puskesmas* in the subdistrict center because of the distance they must cover to get there. Purwati chose to be assisted by the *dukun* near her house when she experienced various health problems and during her pregnancies, childbirths and post-partum recuperations. She and her husband have never used contraceptives.

Bidan Yanti in Negara Ratu Village handled a variety of health complaints from her patients in her very simple practice and provided medical treatment as if she were a doctor. During the day, she worked at the subdistrict office handling population and family planning matters and tended her private practice at her home in the evening. She admitted that she spent more time at home receiving patients than working at the office, which she only did for two or three days every week. Bidan Yanti handled a variety of cases in her practice, ranging from examining pregnancy, assisting in childbirth, administering immunizations, treating simple ailments, performing circumcision, and administering first aid for accident victims.

Yanti charged different tariffs for her services. For treatments for light illnesses, such as stuffy noses, diarrhea, coughs, etc., she charged between Rp. 15,000 to Rp. 25,000, depending on the kind of illness and medicines prescribed. Examinations for pregnancy cost between Rp. 10,000 to Rp. 15,000; circumcision for girls Rp. 25,000, and the minimum charge for childbirth assistance was Rp. 450,000.

Patients usually consult *bidans* because their practices are located closer to the patients homes. Several *bidans* said that they must be flexible in charging their patients because they must consider their financial capabilities. Often, patients who can not afford to pay for treatment asked if they could pay later. Some *bidans* are willing to compromise with their patients and allow them to pay in installments.

The presence of the *bidan* in the villages in North Lampung is truly important for the villagers because they are less expensive than the doctors, whereas they are considered to be careful and quick in handling patients' complaints. The patients often do not care about the limitations of the *bidan*'s qualifications even for treating serious illnesses, such as tuberculosis, which is beyond the scope of the *bidan*'s expertise. Many *bidans* are available for concultations 24 hours a day. There are, however, some *bidans* who will not accept patients after midnight or if they have already gone to sleep.

Because there was a shortage of *bidans* in the area, the existing ones were very busy. Some respondents reported that they had difficulties accessing a *bidan*. When patients arrived at the *pustu* or *polindes*, the *bidan* had often already gone home, but when they went to the *bidan*'s home, sometimes she was not there because she had gone to another patient's house to provide childbirth assistance. As a result, patients must wait for a long time. The unavailability of the *bidan* also influences the lack of health information provided to patients. Several respondents said that when they received KB services, the *bidan* did not provide sufficient explanations concerning either how the contraceptive worked or the possible side effects. Many patients felt that they were not given an opportunity to choose the method of contraception they felt they would be the most comfortable with.

Bidan Melita in Negara Ratu Village in North Sungkai described their intensely busy schedule. Besides serving at the *polindes*, they also are on duty one day in each week at the main *puskesmas* in the subdistrict center. At home, the *bidans* still have their private practices to earn more income. A *bidan* might examine five to ten patients every day.

Nurses availability

There were 387 nurses in North Lampung in 2010. This was an increase from 264 nurses in 2006. They included graduates from the nursing academy (227), SPK (156) and nursing college (4). They were as-

signed to duty at various health facilities, including two at the Health Department, 202 at the *puskesmas*, and 152 at the public hospital. A nurse provides healthcare services that complement the services provided by a doctor and a *bidan*. For instance, they handle outpatient care, treatment for diabetes patients who need regular insulin injections, and various services according to recommendations from the doctor. However, the shortages of doctors and *bidans* in the area force nurses to substitute for the absent doctors.

Nurses in villages also open private practices and receive patients. Several respondents believed that the nurses' capabilities were similar to *bidans*. Since there were no doctors or *bidans* in Hanakau Jaya Village, the villagers depended on nurses. Nurses are usually males who are willing to make home visits when requested. Their fees are similar to those of private *bidans*, i.e., ranging from Rp. 10,000 to Rp. 20,000 for an examination and medicines or vitamin C. There are nurses who will agree to assist in childbirth, although this is clearly beyond the mandate of their expertise and very risky for the patients.

Distribution of Health Workers

Table 3.14. shows the distribution of health workers in 16 subdistricts in North Lampung in 2007.[28] The number of doctors was not the same in every subdistrict. The subdistrict with the most doctors (6) was Kotabumi Selatan, while five other subdistricts only had one doctor each. There were two other subdistricts, Abung Timur and Muara Sungkai, that did not have any doctors. Not only was there a shortage of *bidans* and nurses, but they were also unevenly distributed throughout the district.

[28] Data taken from *Potensi Desa Kabupaten Lampung Utara, 2006*.

Table 3.14.
Distribution of Health Workers by Subdistrict, 2007

No.	Subdistrict	Doctor		Nurse	*Bidan*
		Male	Female		
1.	Bukit Kemuning	1	1	2	8
2.	Abung Tinggi	1	0	1	6
3.	Tanjung Raja	1	1	7	16
4.	Abung Barat	1	0	3	17
5.	Abung Tengah	1	0	5	9
6.	Kotabumi	3	1	7	11
7.	Kotabumi Utara	1	1	2	7
8.	Kotabumi Selatan	3	3	7	11
9.	Abung Selatan	3	1	6	14
10.	Abung Semuli	1	1	5	5
11.	Abung Timur	0	0	3	11
12.	Abung Surakarta	2	2	5	7
13.	Sungkai Selatan	2	2	4	18
14.	Muara Sungkai	0	0	4	5
15.	Bunga Mayang	1	0	2	5
16.	Sungkai Utara	1	0	9	17
	Total	22	13	72	167

Source: *Lampung Utara dalam Angka, 2007*

Conclusion

In the introduction to this chapter, it was stated that there was an indication of a positive correlation between the amounts of health spending per capita with the total number of health workers in a district, as shown in the case of Jembrana. The allocations and use of expenditures also influence the availability of health workers. The districts of Jembrana and North Lampung, that prioritize the development of infrastructure of the *puskesmas* network and not the hospitals in the urban centers, have less of a shortage of health workers, 35% and 67% respectively, in comparison to the districts of Indramayu and Lebak, where the budget allocations target improvement of the equipment and infrastructure in hospitals and where the shortages of health workers come to 82%.

Besides a sufficient budget for reproductive health, appropriate allocations are the keys for successfully reducing the MMR. To significantly reduce the MMR, the budgets and allocations must prioritize support for three programs. First, because there is a serious shortage of *bidans* (see Table 3.15.), there must be a program to increase the number of *bidans*, who are the primary childbirth assistants.

Table 3.15.
Shortages of *Bidan* and Health Workers, 2006

No.	District/City	Shortage of *Bidan* (%)	Shortage of All Health Personnel (%)
1.	Lebak	83.3	82.0
2.	Central Lombok	79.5	66.6
3.	Indramayu	73.3	82.0
4.	North Lampung	70.0	67.0
5.	Surakarta	60.0	(36.0)
6.	West Sumba	58.7	62.3
7.	Jembrana	47.0	35

Second, because the distribution of *bidans* in the villages, especially impoverished and remote villages, is uneven, there must be a program to increase the number of *polindes* that have adequate space and facilities for a *bidan* to live in the village. At the present time, the *polindes* are not able to fulfill their function in reducing the MMR because of several reasons that make it difficult for *bides* to live in the village and to be available to the villagers throughout the day and night:

- Physical conditions of the *polindes* buildings are not suitable for residence. Besides the fact that they are small and very simple, many of them are damaged and dirty because of lack of care.
- There are no facilities for clean water and electricity that support healthcare services, such as a refrigerator for storing medicines, as well as daily needs.
- There are no facilities in the *polindes* for patient examinations, such as beds, benches, tables, etc.

- The wages for the *bidans* are insufficient to support them. Wages are used not only for the *bidan*'s daily needs, but also to pay for electricity and equipment for the operation of the *polindes*.
- There is no protection or guarantee of safety for *bidans* who are assigned to the village. Several doctors expressed concern about the safety of the *bides* who are assigned to remote villages, as there had been reports of kidnappings and rapes of *bides* who had to travel at night to assist patients in childbirth.[29]
- *Bidans* who are married and have families tend to choose to reside with their families and not to live in the *polindes* where they are assigned to work.

Third, because of the poor system of government reimbursement to *bidans* for childbirth expenses, which currently takes up to six months, there must be new regulations to speed up the process, thereby allowing *bidans* to providing better healthcare services.

Baby weighing at the *posyandu*, Jembrana

[29] In the district of North Lampung, the tradition of kidnapping the bride is still practiced. Sometimes it is not part of a formal marriage process, but sometimes becomes the modus operandi for a crime—forcing a woman into marriage.

CHAPTER IV
Village Maternity House (*Polindes*) as a Spearhead of Maternal Mortality Reduction (MMR)

Legislative Resolution No. II/1983 concerning the Outlines of State's Direction (GBHN),[1] states that "in order to increase the standards of health and intelligence of the people, developments in health, including nutrition, must be raised by developing a National Health System (SKN)". This policy gives a mandate to the government to establish health service facilities that will raise the quality of the health of the society in general. This mandate concerns the provision not only of equipment and infrastructure of health facilities, but also of high quality services that are affordable and easily accessed by the society.

Table 4.1 shows SKN's hierarchy of health services from the level of households to hospitals.[2] Hospitals are managed by the provincial government, the district government or private companies. In comparison to the other health service facilities, hospitals are the most complete in terms of services and personnel, which include general practitioners, specialists, dentists, nurses, *bidans*, pharmacists, nutritionists, medical tech-

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[1] "*Sejarah Promosi Kesehatan dalam Kebidanan"*, http://mindaxpromkes.blogspot.com/2009/10/tugas-promosi-kesehatan-sejarah-promosi.html.

[2] "*Sejarah Promosi Kesehatan"*, http://www.promosikesehatan.com/?act=article&id=225.

Table 4.1.
Hierarchy of Health Services

No.	Level	Component or element of health service
1.	Household	Treatment by the individual or family
2.	Community	Treatment by community or health workers of *Posyandu* and *Polindes*
3.	Primary Level Health Service Facility	*Puskesmas*, *Puskesmas Pembantu*, *Puskesmas Keliling*
4.	Primary Referral Level	District Hospital
5.	Secondary Referral Level	Hospital Class A or B

nicians (analysts, radiology technicians, anesthesiologists, physical therapists, etc.), and sanitation specialists.

Services for women's health provided in the hospitals cover nutritional monitoring for expectant mothers, pregnancy examinations, childbirth assistance, postpartum recovery, reproductive health services, and administering of contraceptives. Pregnancy examinations at a hospital include monitoring of weight, height, and blood pressure, examination of the fetus, monitoring of nutrition, and immunization for tetanus. The hospital provides examinations for pregnant mothers, childbirth services and maternal and infant care, including nutritional advice, nursing assistance and treatment of surgical stitches. In addition to these services, the public regional hospitals (RSUD) also provide reproductive health services, including treatments for reproductive organs, infertility, and dissemination of information through the Communication, Information and Education (KIE) program.

The Family Planning (KB) services provided by the RSUD include dissemination of information and counseling, as well as insertion of various contraceptive devices. The RSUD provides services for tubectomies, vasectomies, pills, IUD/AKDR/spirals, injections, implants, and condoms. Diaphrams are not available at the RSUD. Family planning information and counseling, which is provided by a specialist doctor and a *bidan*, focuses on how the various contraceptive devices work, and their

side effects and benefits. Hospitals also provide services such as nutritional monitoring and monthly weighing of infants and children under five years old, which is recorded on the child's Health Card (KMS). The monitoring of child growth includes the measurement of the circumference of the head, body length/height, weight, immunizations, and developmental consultations. Many RSUDs are still unprepared to accept HIV/AIDS patients for initial examinations, as well as provide nursing care and treatment.

The *puskesmas* is positioned under the hospitals at the subdistrict level and represents the primary healthcare unit. Presently there is one *puskesmas* in every subdistrict in Indonesia. The *puskesmas* serves three functions: the center for the development of community health, the center for the formation of community participation in improving their capability to develop a healthy lifestyle, and the center for providing comprehensive, integrated, quality health services. The *puskesmas* has five Health Promotion (Promkes) programs covering: a) Environmental Health (Kesling); Mother and Child Health (KIA), which includes KB; c) Nutritional Improvement; d) Control of Infectious Diseases; and e) Treatments. There are some *puskesmas* in Central Lombok that also provide treatments for HIV/AIDS patients and women's reproductive health services. However, not all *puskesmas* are able to provide treatments for HIV/AIDS patients. North Lampung is currently preparing for the provision of HIV/AIDS treatments in their *puskesmas* system. The *puskesmas* in Jembrana have separate examination rooms for dental treatments and KIA, as well as a simple laboratory that can be used for basic testing of blood, sputum, hemoglobin (HB), malaria, and leprosy. They also have a free ambulance that is available on a 24-hour basis. More than half of the *puskesmas* in Indramayu also have simple laboratories.

Nationally, the ratio of *puskesmas* units to the community is 1:30,000. P*uskesmas* units also service the poor who have Askeskin/Jamkesmas health insurance cards. In Central Lombok, the *puskesmas* also serves patients who are civil servants with Askes coverage and patients who have Poverty Identification Cards (SKTM).

Table 4.2.
Kinds of Facilities and Health Services

Kind of Service	Health Service
Basic health service	Community-Based Health Ventures (UKBM). Forms of UKBM with the broadest distribution are: • Integrated Servies Post (*Posyandu*) • Village Medicine Post (POD) • Village Maternity House (*Polindes*) • Health Fund Group (KDS) • Health Ventures Post (Pos UKK) • Community Health Center (*Puskesmas*), *Puskesmas* with Nursing Facilities (DTP), *Puskesmas Pembantu* (*Pustu* – Sub-community Health Center), and *Puskesmas Keliling* (*Pusling* – Mobile *Puskesmas*)
Secondary health service	• General Hospital • Private Hospital • Specialized Hospital • Specialized Treatment Center (BP), e.g.: Lung BP, Eye BP
Tertiary health service	Hospital with up-to-date equipment, e.g. Mother and Child Hospital, Cancer Hospital, Heart Hospital
Mass health service	Ex.: National Immunization Week (PIN) to eradicate polio
Traditional health service	Traditional treatment

To extend health services to villages and hamlets, the *puskesmas* network develops *puskesmas pembantu* (*pustu* Sub-community Health Center) and *puskesmas keliling* (*pusling* – Mobile Puskesmas). In addition to this, at the community level, there are *posyandus* (Integrated Services Post) and *polindes* (Village Maternity House) that represent cooperative venues between the government and the community. The local government provides the budget for the *posyandu* and the local community provides the personnel. The village or hamlet provides the land for the *polindes*, either communal land or privately owned land, while the government provides the budget, building and health workers.

The question arises: Why haven't these elaborate layers of health services that reach every level of the society been able to reduce the high MMR?

Poor Women have Difficulties Accessing Hospitals and *Puskesmas*

In 1970, the National Health Working Meeting III established just one type of *puskesmas* that conducted seven basic activities. Currently, based on the Puskesmas Working Manual, the *puskesmas* network consists of *puskesmas*, *pustu, pusling, posyandu* and *polindes*, and conducts 18 basic health activities, as listed in Table 4.3.

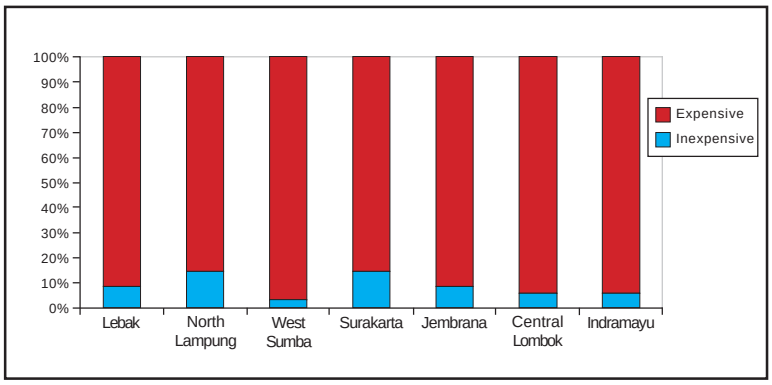
Table 4.3.
Basic Activities of the *Puskesmas*

No.	Basic Activities
1.	Maternal and child health
2.	Family planning
3.	Improvement of nutrition
4.	Environmental health
5.	Control and eradication of infectious diseases
6.	Medical treatment
7.	Community health information
8.	School health
9.	Sports health
10.	Community health treatment
11.	Improvement of employee's health
12.	Dental health
13.	Mental health
14.	Eye health
15.	Health laboratory
16.	Registration and recording
17.	Training for community participation
18.	Training for traditional treatments

Despite the comprehensive program plans, it is difficult for villagers to access the *puskesmas* units that are located in the subdistrict center, and the hospitals in the district center because these health facilities are very far from their villages, the roads they must travel to get there are in extremely poor condition, and means of transportation are not easily available. The results of WRI's research in the seven research areas presented in Graph 4.1. shows the prevailing perception in the society that trans-

portation to healthcare facilities was expensive. Only a small portion of respondents said that transportation to hospitals was inexpensive. The fees for transportation were influenced by a number of factors, including the distance to the healthcare facility, the condition of the roads, and the availability of transportation.

Graph 4.1.
Cost of Transportation to Hospitals



In North Lampung, the cost of transportation to go to the hospital in the Kotabumi subdistrict center ranged between Rp. 2,000 and Rp. 20,000, depending on the distance and mode of transportation, either pedicab, taxicab or public bus. Both government and privately run public hospitals provide free services for Askeskin and SKTM cardholders for pregnancy examinations, childbirth, medical treatments for illnesses, immunizations, and family planning. However, many women in the research areas said that they very rarely went to the district hospitals for examinations or treatments. They went to the hospitals only if they suffered serious illnesses or were referred by the local *puskesmas*. Although medical services are free because they are covered by Askeskin, they did not want to spend money for transportation.

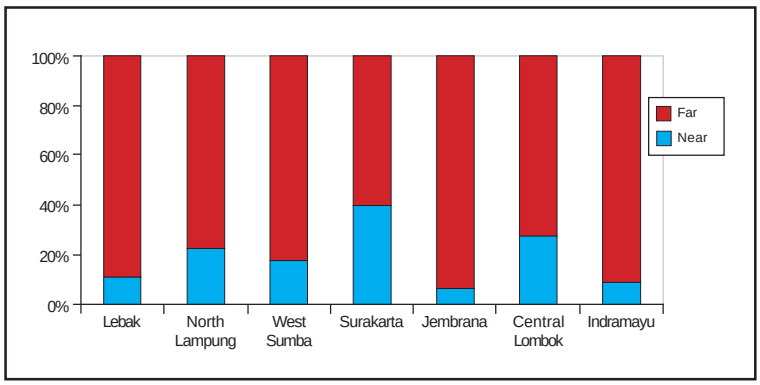
For example, the women in the Hanakau Jaya research area in the Sungkai Utara subdistrict and in Tulungmili (Kotabumi Ilir) said that they were reluctant to go to the hospitals because they must wait for a long

time for the bus that came only twice a day. Also, in order to get to the bus stop they had to walk along dark and isolated footpaths across vast plantations. Attacks and robberies often happened along the relatively quiet road that passes through the plantation in the Tulungmili area. Because of this, women were often not allowed to leave their homes by themselves. Many of them said that when they had health problems they prefered to treat themselves.

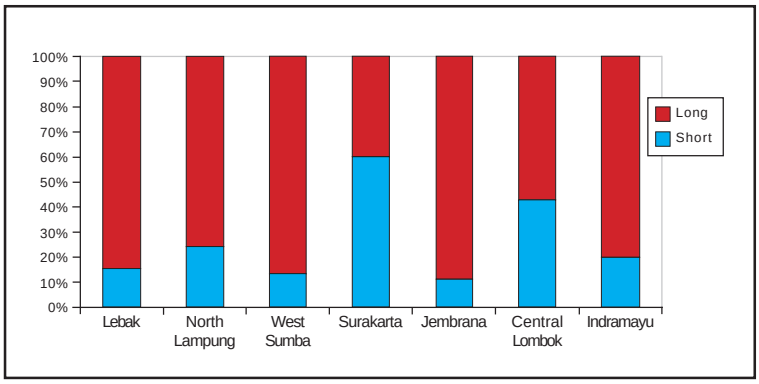
The research results presented in Graphs 4.2. and 4.3. indicate that it is not only hospitals that villagers have difficulty accessing, but also *puskesmas* units. In Jembrana, the problem of the distances to the hospitals and the *puskesmas* is very prominent. The health insurance system that covers residents medical treatments does not address the problem of the transportation costs that villagers incur to access health facilities. In Central Lombok, the distance between Sengkol village and the *puskesmas* in the Pujut subdistrict center is 30 km. Ketare village is closer, but it is still 4 km away from the *puskesmas*. There are no health facilities in Ketare village. Public transportation, either *bemo* or *ojek*, usually takes 90 minutes to reach the furthest hamlets.

The cost of transportation is expensive because of the distance and the length of time needed to reach the *puskesmas* (see Graph 4.4.). Marjah

Graph 4.2.
Distance to *Puskesmas*



Graph 4.3.
Traveling Time to *Puskesmas*



and several other women in Ketare village complained about the expenses for transportation to the health facilities:

> "It's hard for us just to eat, not to mention paying for the *ojek* … If they aren't really sick, then I don't take my family to the *puskesmas*. Just rest a lot at home and they'll get better."[3]

> "There's no money. If there is money, it's better to use it to buy rice and vegetables. We're poor, and we don't have any work."

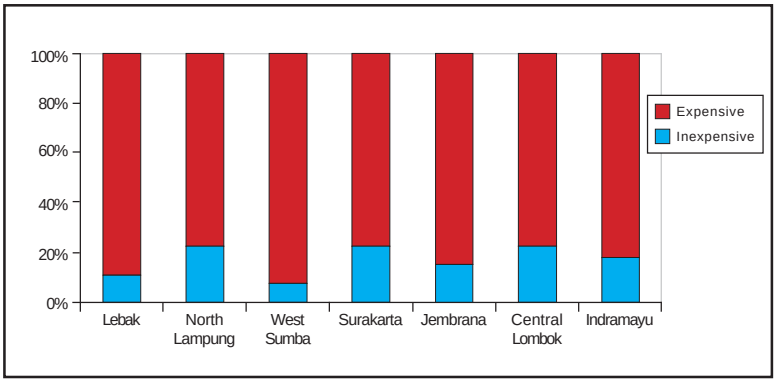
> "For that much money, it's better that I use it to buy food than to go to the *puskesmas*."[4]

These statements show that transportation costs are a heavy burden for poor families. The fee for the *ojek* from the most remote hamlets in Ketare village and Sengkol village to the nearest healthcare facility ranges from Rp. 5,000 to Rp. 30,000. The transportation costs are almost the equivalent of one day's wages for a female laborer in the rice fields.

Limited public transportation is a major problem in West Sumba that has an area of 4,051.92 km^2 and a population of 400,262 living in 17

[3] Interview with Marjah, April 17, 2007.
[4] Interview with Marian from Embung Rungkas hamlet, Ketare village, April 19, 2007.

Graph 4.4.
Cost of Transportation to the *Puskesmas*



subdistricts, 182 villages and 10 wards. Almost 50% of the land in West Sumba is hilly with a steepness ranging from 14º to 40º. Because of the conditions of the land, the residents of West Sumba have built their villages on the tops of hills. This traditional pattern of residence can be traced back hundreds of years to their Sumbanese ancestors. According to the village elders, the higher the village, the safer the villagers feel. They feel protected from enemy attacks, thieves and wild animals. Presently, many people have begun to build their houses in the lowlands and are referred to as "descending from the village". However, their traditional villages must be inhabitated and should not be deserted. Those families that "descend from the village" build new residences without abandoning their social-cultural ties to the old village. The old villages were built in the middle of the forests or on hilltops that are far from the government centers in the lowlands. For example, Kodaka village is 7 km away from the administrative center, Waikabubuak, in West Sumba.

Some hamlets can be reached by *ojek*, but there are still many others that can be reached only by foot. This is one of the reasons why women have difficulty accessing health service facilities. To reach the *puskesmas*, poor women must walk down as much as 4 km from their villages. Women in West Sumba normally walk to various destinations, however, walking a great distance is a serious challenge for pregnant women. At the begin-

ning of their pregnancies, they can walk up to 4 km to go for medical examinations by health professionals. As their pregnancies advance, however, poor women choose to be examined by the *dukun* in their village who also provides a service package to assist in childbirth. If a woman goes into labor and her the husband leaves to call a *bidan* (at the *puskesmas*), it is highly possible that by the time the *bidan* arrives, the baby would have been born with the help of a *dukun*. The reasons for the long travel times are the distance between the villages and the *puskesmas* and the difficulty of the journey to the villages. Almost 90% of childbirths by poor women in these two subdistricts that were the focus of WRI research occurred in homes and were assisted by either a *dukun* or a *bidan*. According to those poor women, the most common reason for delivering at home was the long distance to the health facilities and the *bidan*'s practice. Since there was no public transport between their villages and the subdistrict centers, they were not able to make the difficult journey in the late stages of their pregnancies. An o*jek* was the only vehicle available, but women about to give birth could not ride them.

Gaura, a village in the Lamboya subdistrict is 48 km from Waikabubak, the subdistrict center, offers an example of the villagers' difficulties with public transportation. The winding road to and from this village has sharp turns and runs along the edge of the "ravine of hell". Only trucks dare to carry passengers to Gaura village and several other remote villages in the Lamboya subdistrict. The trucks must crawl along the steep and hilly roads that are filled with pot-holes and are heavily damaged. Sometimes the truck must stop in the middle of a steep hill before it can inch forward. The roads become very slippery and dangerous in heavy rains. Although the fee to ride the truck, which was Rp. 5,000, is considered to be inexpensive, most pregnant women do not dare to ride the truck to get to the *puskesmas* in Kabukarudi village for health examinations.

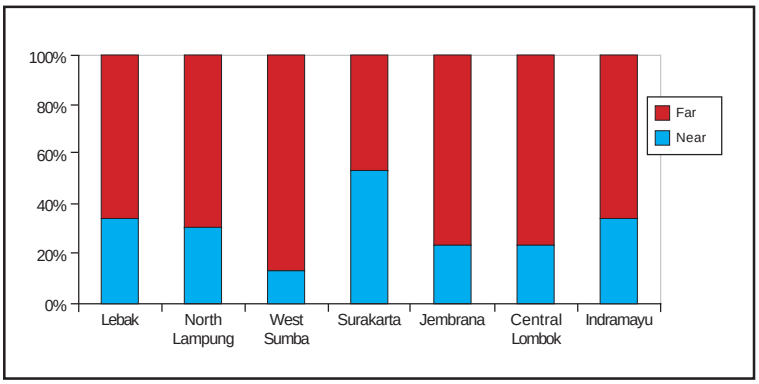
Besides the truck, it is possible to ride an *ojek* to Waikabubak, but it is very expensive, as it may cost as much as Rp. 100,000 for a one-way journey. There are no other means of transport between Gaura and its

neighboring villages. The government has not paved any of the roads in the Gaura area. Many poor women choose to take shortcuts through plantations and forests rather than travel on the road.

The results of WRI research, as shown in Graphs 4.5., 4.6. and 4.7., also indicate prevailing perceptions in the society that the *bidan*'s practice is far away, that it takes a long time to get to a *bidan* and that it is expensive to get to the *bidan*. Graph 4.6. shows that only in the city of Surakarta did the majority of respondents say that a *bidan*'s practice is easily and quickly accessible. In the other areas, conditions are much worse. Paile Deke, from Kalembu Kuni village in Waikabubak,[5] is one of the women who cannot access a *bidan*. Four of her children have died either in childbirth or shortly after birth. Paile did not know why her babies died. She could only say, "Usually, a *dukun* helps me. When the children are sick, we go to the *dukun*. Usually, they recover." Often these fatalities are related to the difficulties in accessing hygienic childbirth facilities.

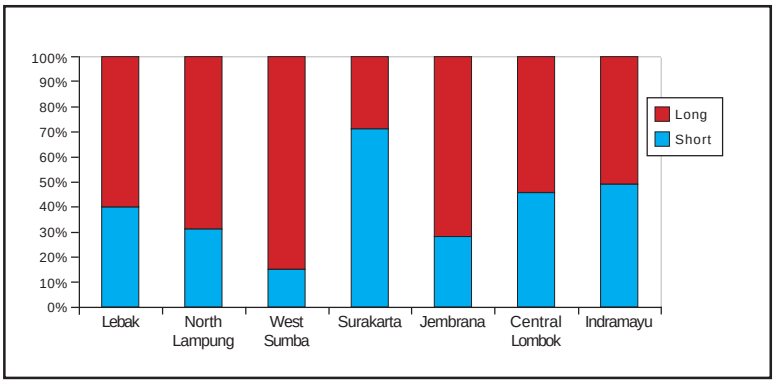
Wini Mude,[6] who resides in the same village as Paile, has suffered two miscarriages. She said that she always consulted a *dukun*.

Graph 4.5.
Distance to a *Bidan*

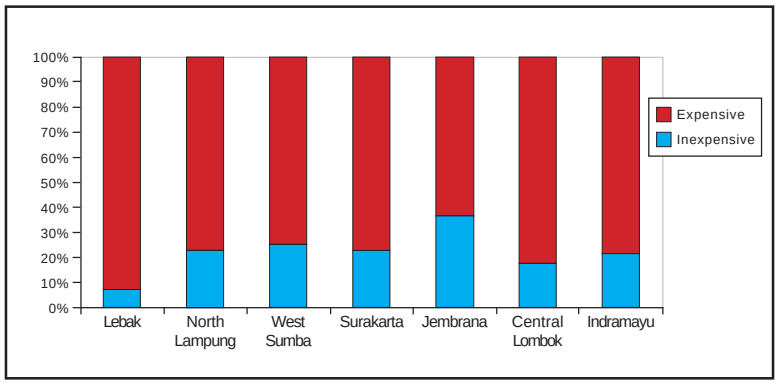


[5] Interview with Paile Deke, December 6, 2007.
[6] Interview with Wini Mude, December 8, 2007.

Graph 4.6.
Time of Journey to a *Bidan*'s Practice



Graph 4.7.
Cost of Transportation to a *Bidan*



"My mother always took us to be treated by the *dukun*. All of us in the village usually go to the *dukun*. It's close and easy to get there … It is only recent that the *bidan* has started to come to this village. We didn't know that the *bidan* could do examinations. We don't know what to go to her for. We can go to the *dukun* for everything. We go there when we are sick, when we are pregnant and to give birth. The *dukun* takes care of everything."

Going to see a dukun who lived in the village was much cheaper. Wini often gave the *dukun* betel leaves as payment for the assistance. To

consult a *bidan*, Wini must pay for the transporation costs of riding an *ojek* because the *bidan*'s practice is far away.

The distance and conditions of the roads to the villages present a major obstacle for *bidans* to offer assistance to the villagers. Betty, the *bides* in Kodaka, said that as a *bidan* she must be picked up and escorted home by the patient's husband whenever they need her assistance. Often the *bidan* is contacted in the middle of the night and must travel on very poor roads. Sometimes the *bidan* is afraid to travel to the patient's house for safety reasons. However, if the patient is in critical condition, then the *bidan* must go to her house. Estiana Multi, the *bidan* in Kalembu Kuni, explained:

> "Actually, it's not that far, but because the area is very hilly and the road twists and turns, I felt like I almost died on the way to their village."[7]

Many *bidan* must face similar conditions every day to reach their patients' homes. This heavy burden arouses concern in the community. The residents in the most remote hamlet in Kalembu Kuni village took the initiative to take women who were about to give birth to live temporarily in another villager's home that was closer to the *bidan*. They have done this for almost one year. Although not all of the hamlets have undertaken this initiative, the *bidan* in the area is grateful that she can reach at least some of her patients more easily.

The distance of the villages, the difficulty of transport, and the expenses of transportation fees to get to a *puskesmas* are the reasons why the *puskesmas* cannot achieve its target of serving 100% of the area's medical needs. In West Sumba, for example, visits to the *puskesmas* reached only 61.37% of the actual needs. This condition confirms WRI's survey results in Central Lombok regarding the community's choice for treatment

[7] Interview with Estiana Multi, December 8, 2007.

of general illnesses. Table 4.4. shows that 46.2% of men and 36.5% of women still chose to buy their own medicines to treat themselves.

Table 4.4.
Choice of Place of Treatment in Central Lombok

Place of Treatment	Men (%)	Women (%)
Puskesmas	34.5	36.5
Clinic/doctor/*bidan*	17.6	22.6
Buy medicine themselves/other	46.2	36.5
No treatment	1.7	4.3
Total	100.0	100.0

In order to bring health services to the people in the villages and hamlets, the *puskesmas* is supported by the Sub-community Health Center (*pustu*) and mobile *puskesmas* (*pusling*). P*ustu* is smaller than *puskesmas* and it covers one or two hamlets with a target population of 2,500 people (outside of Java) to 6,000 people (Java and Bali). There are 60 *pustus* in West Sumba. Since the population was 400,262 people, one *pustu* served 6,671 people. To achieve the ideal ratio, the district needed 100 more *pustus*.

P*ustus* provide the best possibilities for medical care for the poor in communities that are far from a *puskesmas*, such as those who must travel at least two hours over damaged or dangerous roads. However, in general, as the Health Department admitted, the number of medical workers in *pustus* is very limited. Usually, there is only one *bidan*/nurse who also serves as the administrative head of a *pustu*. All of the tasks, both medical and administrative, are undertaken by one worker. If this worker goes to the subdistrict center or to the *puskesmas*, then the *pustu* must close and patients must return later for treatment. Therefore, *pustus* are not yet effective in extending medical care to the villagers.

The community assists the government in implementing healthcare services at the community level by participating in the Integrated Services Post (*posyandu*) and the Village Maternity House (*polindes*) programs. These are hybrid programs are a collaboration between the government

and the community. Each hamlet is required to have a *posyandu*. The *posyandu* session is held once every month in each hamlet, usually between 9 a.m. to 12 noon. A bidan and a nurse from a nearby *puskesmas* usually come to run the *posyandu* session. They are helped by two to five assistants. The majority of the assistants are female members of the local chapter of the Advancement for Family Welfare (PKK), the neighborhood women's association. One day before the *posyandu* session, one of the assistants reminds the pregnant women and mothers of infants and children under five years of age in the neighborhood to attend the *posyandu* session the next day. The local assistants help the *bidan* to weigh the infants and record the information. In Indramayu, the *posyandu* session includes pregnancy exams and immunizations for bacilus calmette-gueri (BCG), diptheria-pertussis-tetanus (DPT), hepatitis, smallpox, polio, and tetanus, as well as the provision of vitamin A and iron boosters.

The number of *posyandu* and *polindes* in operation in the country is impressive. Table 4.5. shows that in the seven WRI research areas, on the average, one *posyandu* serves approximately 540 people (in Indramayu) to 914 people (in North Lampung). These statistics are very impressive considering that the ideal ratio for one *bidan* or nurse is to serve 1,000 people (see Table 3.1. in Chapter III).

Table 4.5.
Number of Posyandu in Seven Research Areas

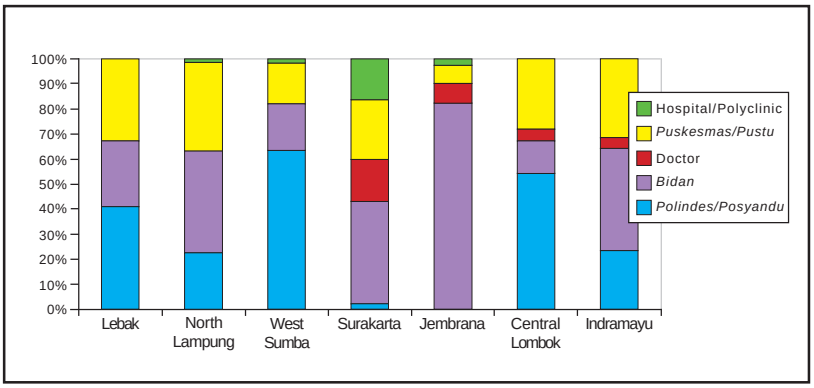
District/City	Number of Posyandu (year)	Population (ratio of Posyandu: population), 2005*
Surakarta	586 (2006)	506,397 (1 : 864)
North Lampung	606 (2006)	554,136 (1 : 914)
Indramayu	3,126 (2004)	1,689,247 (1 : 540)
Jembrana	325 (2005)	247,102 (1 : 760)
Lebak	1,646 (2006/2007)	1,154,890 (1 : 701)
Central Lombok	1,131 (2007)	810,645 (1 : 716)
West Sumba	576 (2006)	400,244 (1 : 694)

Source: Compiled by WRI from various sources

* *Source*: SPAN (Census of Aceh and Nias), SUPAS (Population Census) 2005, quoted from www.datastatistik-indonesia.com

Graph 4.8. shows the results of the WRI survey concerning women's choices for health services during pregnancy. The data indicates that the majority of women in Lebak, North Lampung, West Sumba, Central Lombok, and Indramayu chose to have examinations at the *posyandu* or *polindes*, while in Surakarta and Jembrana, more women chose to consult a *bidan* for pregnancy exams. If *posyandus* and *polindes* are evenly distributed and function well throughout every district and city in Indonesia, that is, they are provided with adequate equipment and facilities, human resource support and budgets, they should be able to address the problem of the persistently high MMR. But, why has this not yet happened?

Graph 4.8.
Choice of Health Facility During Pregnancy



Posyandu Facilities in the Seven Research Areas

The *posyandu* is a health service unit that is implemented *by* the community on a volunteer basis and is *for* the community with technical support from the *puskesmas*. It is a venue for community participation to support the health development of mothers and children. The *posyandu* offers five basic health programs: Family Planning (KB), Mother and Child Health (KIA), nutrition, immunizations, and treatment for diarrhea. Usually there are three to five assistants who help the *bidan* to administer the *posyandu* programs. The wife of the administrative head of the hamlet usually selects women in the hamlet to become *posyandu* assistants or they volun-

teer themselves. The assistants also actively disseminate information regarding health and organize women to participate in the *posyandu*.

Ideally, a *posyandu* has five tables to accommodate the following activities:

1. **Table 1:** Health assistants register visitors who are divided into three groups: infants and children under five years, pregnant and nursing mothers, and married women in their childbearing years.
2. **Table 2:** Health assistants weigh infants, children and pregnant women to monitor their development.
3. **Table 3:** Health assistants record the weights taken at Table 2 on the individual Health Cards (KMS) for both infants and children, and pregnant women.
4. **Table 4:** Medical workers, such as the *bidan*, are available for consultation and information for mothers concerning nutrition and family planning.
5. **Table 5:** *Bidans* or paramedics from the *puskesmas* administer immunizations, insert contraceptive devices, treat infants, and conduct pregnancy exams. Any cases that cannot be handled at the *posyandu* are referred to the *puskesmas*.

Based on WRI research, the first reason why *posyandus* have not yet become the spearhead of the effort to reduce the MMR is the limitation of their capacities and services. There is not a single *posyandu* that has the capacity to run the complete five-table system.

There are four kinds of *posyandu* in accordance to their facilities and services provided.

a. **Primary *Posyandu***

   This kind of *posyandu* is run by less than five assistants. They do not have routine activities or facilities for infant or child weighing. The signboard is painted red.

b. **Secondary *Posyandu***

   This kind of posyandu is run by less than five assistants and they have routine infant and child weighing activities. The signboard is painted yellow.

c. Tertiary *Posyandu*

This kind of *posyandu* is run by five assistants and they have routine activities and funds that are gathered voluntarily from the community to finance the *posyandu*'s operational budget. The signboard is painted green.

d. Independent *Posyandu*

This kind of posyandu is run by at least five or more assistants. They have funds for operational activities and run additional programs, such as Early Childhood Education (PAUD) and a Medicinal Herb garden

The majority of *posyandus* are of the first two categories. According to WRI's research results, in 2005, of the 563 *posyandus* in North Lampung, 33.57% were Primary *Posyandus* and 40.32% were Secondary *Posyandus*, while only 22.74% were Tertiary *Posyandus*, and only 3.37% were Independent *Posyandus*. Meanwhile, in Lebak, of the existing 1,646 *posyandus*, 78.31% were Primary *Posyandus*, 15.30% were Secondary *Posyandus*, while only 6.25% were Tertiary *Posyandus* and 0.12% were Independent *Posyandus*. In the same year, in North Lampung, the 563 *posyandus* consisted of 33.57% Primary *Posyandus*, 40.32% Secondary *Posyandus*, 22.47% Tertiary *Posyandus*, and only 3.37% Independent *Posyandus*.

The second reason for the lack of effectiveness of the *posyandu* system is its uneven distribution at the village level. Due to limited facilities, many villages centralize the *posyandu* services in the village center and do not venture out to the hamlets. For instance, the *posyandu* for Kalembu Kuni village in the Waikabubak city subdistrict in West Sumba is located at the village head's office.

The third reason is the lack of sufficient human resources to serve as *posyandu* assistants and nurses to provide reproductive health services. For instance, when the *bidan* could not report to the *posyandu* at Kalembu Kuni in Waikabubak, West Sumba, because she was on maternity leave, the *puskesmas* sent a nurse to replace her. The nurse, however, was not able to explain the uses and risks associated with each contraceptive

method. During the pregnancy exams, the nurse, who was assisted by one *posyandu* assistant, only took and recorded the women's weights in her KIA book without conducting any other medical examiniation. Many *posyandu* assistants are even less able to provide information about pregnancy, childbirth and the postpartum period. The capacity of the *posyandus* to provide healthcare services and information about women's reproductive health is very limited.

The fourth reason is that there is no system that guarantees the provision of financial compensation for *posyandu* assistants. Presently, *posyandu* assistants are volunteers, and the voluntary character of the system is actually threatening the continuity and quality of *posyandu* services because many assistants cannot continue to allocate their time and energy without receiving compensation. For instance, in Lebak, there were 6,142 *posyandu* assistants, but only 3,450 were active. Because of this, several *posyandus* provided incentives for their assistants. In North Lampung, *posyandu* patients were charged around Rp. 10,000 to Rp. 15,000 for contraceptive injections that should be provided for free by the Health Department. The patients were told that the fees were for injection needles. Patients were also required to pay a fee of between Rp. 1,000 to Rp. 5,000 for other injections that should be free-of-charge for the same reason. The *bidan* at the Kalembu Kuni *posyandu* in West Sumba charged Rp. 3,500 for each contraceptive injection that should be provided for free. The money collected from the charges for injections were used as operational funds for the *posyandu* to buy tea and snacks for the staff. The remainder of the money was then given to the *posyandu* assistants. Several *posyandu* assistants in West Sumba said that they received an incentive between Rp. 10,000 to Rp. 15,000 every month, which was considered to be small compared to the work that they had to do. Since the beginning of 2007, it was decided that the assistants should receive an incentive of Rp. 20,000 per month. However, they said that they had received that amount only once.

The Health Department in North Lampung actually provided funds for incentives for *posyandu* assistants. However, the allocation was very

small, i.e. Rp. 8,000 per month per assistant, and only for six months in the fiscal year of 2007. This allocation was provided just for a maximum of five assistants for each *posyandu*. The assistants who have been active in implementing the *posyandu* activities complained about the small budget. They felt that the budget for incentives was too small in comparison to the work that they do, which includes cooking meals to be distributed every day to malnourished children under five years old for three full months.

The fifth reason that the *posyandu* network is less than effective is that the budget allocations for *posyandu* activities are too small. In North Lampung, *posyandu* activites were funded by the revitalization of the *posyandu* budget established by the governor of Lampung, which amounted to Rp 1.8 million for one year. These funds were channeled to the accounts of the *puskesmas*, then distributed to *posyandu* units in each village for the production of uniforms, technical manuals, and equipment, as well as the Provision of Additional Meals (PMT) program for malnourished *balita*. One can imagine the amount of funds required to finance all of these activities for one year. If each monthly session requires a minimal budget of Rp. 100,000, then each *posyandu* will need Rp. 1,200,000

Waiting for the routine monthly baby examination at the *posyandu*, West Sumba

each year. Since each village has a minimum of two *posyandus*, the current revitalization fund of North Lampung provides little of the required amount needed to finance all of the *posyandus* activities for one year.

In Surakarta, the Health Department allocates only Rp. 900,000 annually per *posyandu*, which was an increase from the Rp. 600,000 that was allocated in 2006. These funds that are channeled to the *posyandu* via the *puskesmas* must be spent extremely wisely to finance the *posyandu's* activities for one year, which includes providing supporting equipment, additional food, and transportation costs to assistants who need them. Although the budget has been raised, the assistants still feel that the budget is not sufficient to cover the operational costs. Each *posyandu* session that provides services for between 50 to 100 patients, as well as provides tea and snacks for the assistants costs approximately Rp. 100,000. The funds from the APBD are only enough to finance nine *posyandu* sessions in one year, and no funds could be allocated for equipment and compensation for transportation. To make up for the lack of funds, *posyandu* assistants receive additional funds from contributions from the neighborhood wards and private donors.

The Difficulties of Opening and Operating a Village Maternity House (*Polindes*)

The majority of residents of West Sumba who lived in the highlands and hillsides that were far from the main roads described the difficulties that pregnant village women had when they needed to go to health facilities in the subdistrict center. The remoteness of many villages, poor roads, and the lack of public transportation are reasons why it necessary to establish one *polindes* in every village in West Sumba. The *polindes* building should have adequate space for mothers to give birth in and to recover, and also residential quarters for the *bides*. The pregnant women said that it was easier to access the *posyandu* and *polindes* than the *puskesmas*. Besides the fact that the *posyandu* and *polindes* are closer to their residences, the women

often have already established comfortable, informal relationships with the *bides*.

The *bides* at a *polindes* undertakes several duties that include the provision of healthcare services to all of the villagers in the *polindes* area where she resides. The services provided at the *polindes* are similar to those provided at the *puskesmas*, i.e., healthcare for mothers and children, family planning, immunizations, and childbirth assistance. The *bides* is on-call at the *polindes* for 24 hours a day, except for the one day in each week when she is on duty at the main *puskesmas* in the subdistrict.

Currently, there are many villages that do not have a *polindes*. None of the four villages surveyed by WRI's research team in West Sumba, for example, has a *polindes*. The *bides* must search for an alternative venue for the *polindes*. Bides Kodaka explained:

> "I took the initiative to ask whether it would be okay to put the *polindes* in one of the villager's houses, but the *puskesmas* office said that it was too close to the *puskesmas*. The priority is to build a *polindes* in the villages that are farther away, but there isn't any funding yet. The idea has already been proposed to the Musrenbang."[8]

The first reason why the *polindes* has not become the spearhead in the effort to reduce the MMR is because the poor conditions of the buildings and inadequate facilities. The *bides* in North Lampung complained about the smallness of the *polindes* building, which measured 2 x 3 m, and did not have furniture for examining patients, electricity or clean water. The government provided only medicines and basic equipment for medical treatment and the *bides* had to supply the other needs herself.

Of the 100 *polindes* units in Central Lombok, 37 were damaged and needed repairs. According to a *bides*, although the remaining 63 *polindes* units were not damaged, they had to be furnished and equipped so that

[8] Interview with Bety Mode, a *bidan* in Kodaka village, December 12, 2007.

they would be suitable for living and providing services. Other *polindes* units were well-built, but they did not have running water, electricity or bathrooms. Many of them had only one examination room and bed, making the *polindes* unable to serve more than one patient at a time. If two patients arrived at the same time, the *bidan* had to make a decision on who would give birth first. This kind of decision is not always easy to make. In an FGD conducted by WRI,[9] it was revealed that:

> "A *bidan* told one patient to go home because she thought it was not yet time for her to give birth. The only bed in the *polindes* at that time was being used by another patient who was also in labor. Not long after she went home, the patient unexpectedly gave birth at home and the baby died. Upon hearing the bad news, the *bides* ran to her house to help, but it was too late. The *bides* was questioned by the *puskesmas* and the Health Department in the district center. She was accused of negligence because she had ordered a patient who had come to the *polindes* to give birth to go home."

The second reason for the ineffectiveness of the existing *polindes* units is that they are located in unsafe remote areas. Since the *polindes* is built on communal land, the community or the village administration tends to assign unproductive land with low commercial value that is located far from the village residencies for the *polindes*. According to one *bides*, several *polindes* units are situated on abandoned cemeteries. The remote locations of the *polindes* make it difficult for the *bides* to provide emergency assistance, and several instances of robberies have occurred in the most isolated *polindes*. The *bides* in North Lampung who were still single felt very unsafe living alone because there was a cultural tradition of kidnapping prospective brides.

Faced with difficulties of finding land for a *polindes*, Bidan Kodaka in West Sumba took the initiative to provide 24-hour service in the house

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[9] FGD Presentation of the Temporary WRI Research Results, "*Akses dan Pemanfaatan Fasilitas Pelayanan Kesehatan Reproduksi bagi Perempuan Miskin di Lombok Tengah"*, June 9, 2008.

of a villager who had voluntarily let her use it as a *polindes*. Bidan Kodaka provided routine health services in this privately-provided furnished space. Her initiative successfully brought health services to the community. Many women went to the Kodaka *polindes* for pregnancy exams. Several other *bides*, such as the *bides* in Kalembu Kuni, similarly borrow the office of the Village Head for the temporary *polindes*.

The third reason why the existing *polindes* has not become the spearhead in the effort to reduce the MMR is that many *bides* do not reside in the *polindes*. Therefore, they are not available to treat patients on a 24-hour basis. For a variety of reasons, including the poor condition of the *polindes* building, minimal facilities, and the remote locations of the *polindes*, many *bides* prefer to return to their homes to open their own private practices to supplement their inadequate salaries. A *bidan* with a temporary work status (PTT) receives a salary of only Rp. 250,000 per month during her first year of employment. This salary is increased to Rp. 600,000 per month after one year of employment. After she is hired as a civil servant, during her first year she will receive 80% of her full salary, or Rp. 851,000 per month. She will receive her full salary, Rp. 900,000 per month, after her first full year of employment as a civil servant.

WRI research findings reveal that the *polindes* in the Gerunung subdistrict in Central Lombok has not yet been used by the *bides* because she chose to live in her own home so that she could open a private practice. The *polindes* building next to the village head's office was empty and deserted. Similarly, the *polindes* in Ketare village had been empty for four years and the building was damaged. When the *puskesmas* finally appointed a *bidan* to Ketare village in 2007, she did not live in the *polindes*. Although she carried out her duties in Ketare, she lived in Sengkol village, which was in the Pujut subdistrict center. She went to Ketare only for the scheduled *posyandu* activites and when villagers needed her services. According to the villagers, the *bides* did not live in Ketare because she did not feel safe there and the *polindes* building was not suitable for residence.

Katarina

Gaura village, Lamboya subdistrict, West Sumba

The Difficulty of Accessing Health Service Facilities and Personnel

Katarina, 16 years old, is from Gaura village in the Lamboya subdistrict in West Sumba. At her young age, she has already had four children. One child died shortly after birth. Katarina said that she married at a young age because her family was poor. Her husband was a farmer. After she finished with her housework and childcare, she always helped her husband in the vegetable garden to earn the family's income.

Katarina admitted that she experienced several problems with her reproductive system. She often felt pain in her vaginal area, especially after sexual intercourse with her husband. Sometimes she experienced bleeding after sexual intercourse, and her vagina was often irritated and very hot. She also had cramping in her lower abdomen. She has had problems with her reproductive organs for a long time. When she went for an examination, the *bidan* in her village just gave her pain-killers for two days. When the pain returned, Katarina resigned herself to her condition. She said,

> *"The bidan is lazy. She doesn't see or examine outsiders properly. She treats only her own family very well."*

Katarina had never told anyone else, even her husband, about her problems because she didn't know how serious her illness was and she was afraid to tell her husband or other relatives.

When she gave birth to her last child, Katarina just called the *dukun* in her village. She did not want to ask for the assistance of a *bidan*. The birth was unexpectedly difficult. She felt nauseous for almost two full days and the contractions would not stop. She felt as if she would die. She remembered that her neighbor had suffered similar difficulties and died in childbirth because of heavy bleeding. When she could no longer stand the pain, Katarina asked her husband to get the *bidan*. Before the *bidan* arrived, the baby was born safely. However, the bleeding did not stop and Katarina suffered a terrible headache. She became very weak and fainted. Her last memory before she fainted was the *dukun* screaming histerically upon seeing the heavy bleeding.

After administering several injections, the *bidan* asked Katarina's husband to find a vehicle to take her to the *puskesmas*. This was very difficult to do. Gaura is located high on the mountain and the journey to the *puskesmas* over very poor roads takes two hours. The only means of transportation was a truck that operated only once a day. Otherwise, villagers must hire an *ojek* for Rp. 100,000. The journey is very rough. There have been several cases in which women who were hemorrhaging died during the long journey to the *puskesmas* because of the difficult conditions of the roads.

Because they had difficulty getting a vehicle to take them to the *puskesmas*, the *bidan* panicked and went to get help from several other *bidans* in the area. After working for four hours, the *bidans* were able to stop the bleeding and Katarina's condition slowly improved.

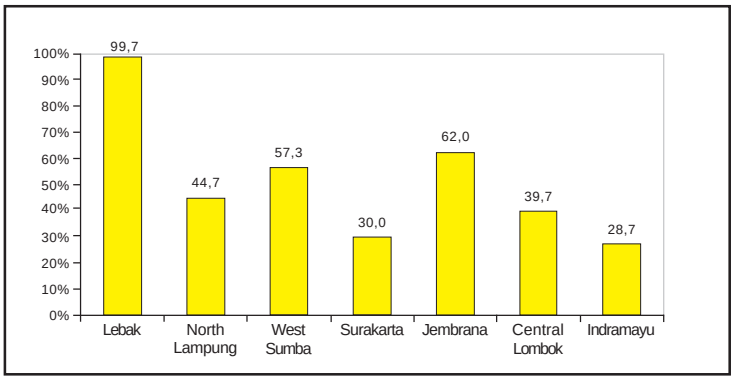
Social Health Insurance does not Solve the Problems of Poor Women in Accessing Reproductive Health Services

Candidates running for local offices often used social health insurance as a campaign promise directed at families in both rural and urban areas. Jembrana's social health insurance policy that covers all residents has been replicated in a number of other districts. Basically, social health insurance intends to ease the economic burdens of poor families. WRI research, however, shows that there were still several problems concerning the implementation of social health insurance in the seven selected areas.

Graph 4.9. indicates that many poor people did not yet have social health insurance and the percentage of Askeskin holders in the seven research areas varied. The smallest percentages of Askeskin cardholders were in Indramayu and Surakarta, 28.7% and 30% respectively, while the highest percentage was in Lebak, 99.7%. The local governments allowed poor citizens who did not have Askeskin cards to apply for free health services with their SKTM. There were poor villagers in several remote villages in West Sumba, such as Gaura, who had not yet received Askeskin cards. They still used the 'yellow card' or old Social Security Network (JPS) card as proof of their economic status when they went for treat-

ments at health facilities. Several poor women said that before they received Askeskin cards, they had to pay in full for the treatments that they received at the *puskesmas*. Poor women did not pay for childbirth assistance when they used the Askeskin card, SKTM or other insurance.

Graph 4.9.
Health Insurance Policy Holders



Possession of Askeskin cards or SKTM does not however, automatically provide easy access to existing healthcare facilities in the region. The mountainous conditions, bad roads, distance, infrequent public transportation, and poverty are all reasons why Askeskin cardholders have difficulties accessing health service facilities. Those obstacles reduce the effectiveness of social health insurance in providing poor women with access to reproductive health services. As a result, there are still many poor women living in remote villages, far from health services, who prefer to give birth at home with the assistance of local *dukuns* because it is less expensive and they are readily available in the village where they reside. If they decided to go to see a *bidan*, they must pay for transportation, lodging and meals for the accompanying family members. Meanwhile, payment for the *dukun* ranges only between Rp. 5,000 to Rp. 30,000, plus betel leaves and rice. Sometimes, a patient will also give the *dukun* a piece of cloth. This is far less expensive than having to pay Rp. 100,000 to Rp. 200,000 for the services of a *bides*, or Rp. 200,000 to Rp. 1,000,000 for a private *bidan*'s services.

Patisina

Golulowo hamlet, Kalembu Kuni village, Waikabubak city subdistrict, West Sumba

"If You're Hungry, Why Do You Have to Go to the Bidan?"

Patisina was interviewed in Golulowo hamlet in Kalembu Kuni village, approximately 7 km from the center of Waikabubak city. Her house measured 6 x 6 m, had a dirt floor and bamboo walls. Patisina lived with six other members of her family. At 27 years of age, Patisina had been pregnant six times. She had given birth to four children and had experienced two miscarriages.

Patisina must wake up very early in the morning to cook for her family. Before leaving for work in the fields, she must be sure that her daily housework, including fetching clean water for cooking, was completed. The walk to and from her house to the water source took 90 minutes. Patisina carried two 5-liter jerrycans and a bucket that she balanced on her head to get the water. This amount of water usually lasted between two to three days. Patisina did this even when she was pregnant. When the housework was finished, Patisina helped her husband clear the fields and plant vegetables and tubers in the dry land. The field was located far from their home.Often she brought cassava from the fields to cook and dry in the sun. She either gave this cassava to her family to eat when they came home or stored them away for future consumption when they ran out of rice.

As they were classified as a poor family, they had Askeskin cards. During the rainy season, they planted rice that would support them for six months. During the dry (hungry) season, Patisina had to work harder to plant vegetables that she would then trade for rice. When asked about her income from her vegetable sales, Patisina replied:

> *"The income isn't very much, only Rp. 20,000 each time. But how else will we get money? We don't have anything, we don't have pigs … If we don't have money, then usually we eat the cassava that we harvest."*

Patisina felt that the two miscarriages she experienced were caused by her exhaustion from working in the fields. Even though she suffered from heavy bleeding, Patinina just consulted the *dukun* in her hamlet about her condition. In general, she had several reproductive health problems, including pain in her vaginal area, itchiness, unusual vaginal discharges, and pain in her lower abdomen. She had never been examined at a healthcare service facility.

With the assistance of a *dukun*, Patisina gave birth to her fourth child at home normally and without much difficulty. However, she had heavy postpartum bleeding. The *dukun* gave Patisina betel leaves that she had chewed and prayed over to eat. After bathing the baby and placing it on a cloth next to Patisina, the *dukun* left and promised to check on Patisina every day because she lived close by. Patisina's husband gave her Rp. 100,000.

After giving birth, Patisina was very weak and could only lie down. She could not do anything. For more than one week, she suffered heavy bleeding, soiling three cloths every day. She had a high fever, her vaginal area emitted an unpleasant odor, and her breasts were very painful. She lay in bed for almost two weeks. Because of her weak economic condition, Patisina did not consult a *bidan*. She only took her baby to the scheduled *posyandu* when the baby was three weeks old.

Conclusion

From the above discussion of reproductive health problems, limited we can see that the primary problems concerning access to healthcare service facilities are poverty, bad road conditions, limited access to means of transportation, high transportation expenses, and the distance between the health service centers and the residences of the population. Because of those problems, social health insurance, such as Askeskin and other schemes introduced by the local governments have not been effective in helping impoverished women to access health services. Instead, many

poor women tend to use the services of the local *dukun* to assist in the childbirth process at home.

Because the distance to the *puskesmas* and the *bidan,* and the expenses involved in accessing them present challenges for the health insurance system, there is no other choice for the government than to improve and develop the *posyandu* and *polindes* network to provide impoverished women with full access to reproductive health services. Since the high MMR is correlated to isolation and poverty, public funds for the *posyandu* and *polindes* systems must be significantly increased. With the *puskesmas* located in the subdistrict centers, it is the *posyandu* and the *polindes* in the hamlets that must become the spearheads in the effort to reduce the MMR.

The question now is whether there is political will on the part of the government to save impoverished women's lives by supporting the development of *posyandu* and *polindes* networks so that poor women can easily and quickly access affordable and quality reproductive health services.

Monitoring child development at the *posyandu*, West Sumba

Saidah

"Childbirth Assisted by her Husband because they were not able to Pay for Health Facilities"

Saidah (41 years old) is the mother of six children. She married Joko Saryono when she was 21 years old. They are both from Surakarta. Saidah and her husband have never gone to school. They can not read or write and have never joined a 'combat illiteracy' program. Saidah helped her husband to make shuttlecocks in their home. They received orders irregularly. Their monthly income was not stable and hovered around Rp. 600,000. Saidah said that they have not had many orders for the last six months, so they had to work hard at getting odd jobs to support their family.

Saidah has been pregnant nine times and has given birth to six live children. She has suffered two miscarriages and was currently pregnant. Because of poverty and her lack of knowledge about women's reproductive health, Saidah has never gone for a pregnancy examination or consultation for complaints regarding her reproductive system (e.g., unusual vaginal discharges and itchiness). Saidah said that she had experienced several problems with her reproductive system, including complications during labor, such as extreme nausea that lasted more than 24 hours. She also suffered heavy postpartum bleeding and pain in her breasts. However, she did not go to a health service center for an examination. She chose to rest at home. Saidah and her husband did not use contraception, which was too expensive for their unstable monthly income. When her sixth child was born, Saidah did not go to a *bidan*. Her husband assisted her husband by using whatever equipment they had at home. They could not afford to pay for health services at a hospital. Saidah's husband used a razor that was lined with tumeric to cut the baby's umbilical cord. Only after the baby was born and the cord was cut, did he call a *bidan* to assist them. In this way, they only had to pay Rp. 50,000 for her services.

Saidah lived in an impoverished area that had easy access to the healthcare facilities in the Semanggi subdistrict. There was a *pustu* and a

pusling that provided services three days each week. Health workers were available at *bidan*s practices, doctors' practices, and clinics, including an STD clinic that provided free services. Regardless of the availability of various health facilities, Saidah and her family were not able to access them because they were afraid that they would be asked to pay for the services. At the *posyandu* that should provide free immunizations, patients were charged Rp. 6,000 or asked to voluntarily contribute to cover administrative costs.

As an Askeskin cardholder, Saidah had unpleasant experiences when being treated at the hospital. Once she gave birth as an Askeskin cardholder at the local hospital near her home. She felt contractions early in the morning at 4:30 a.m. and immediately went to the hospital. When she got there, she was told to lie down in the delivery room and waited for the *bidan* who was in the middle of her morning prayers. Saidah's contractions increased and she called to the attendants to help her, but no one was there. Eventually, Saidah gave birth to her baby without any assistance because the hospital attendants arrived one hour later. The baby had turned blue because it ingested some of the amniotic fluid and then died. Ever since then Saidah refused to give birth at the hospital even though it was free for Askeskin cardholders.

Baby weighing, West Sumba

CHAPTER V
Traditional Midwives as Partners

Since hospitals, *puskesmas* units, and *bidans* are often too far for villagers to reach and too expensive for the poor, and many villages still do not have a *polindes* and *posyandu*, *dukuns* should not be blamed as the villains that cause the high MMR. How can we conduct "don't give birth at home" campaign amongst impoverished women who live in remote villages with poor infrastructure of roads and little access to public transportation? The "don't give birth at home" campaign would be effective only when quality healthcare facilities for women's reproductive health, including childbirth, are easily accessible and affordable. In the meantime, the role and capacity of *dukuns* must not be marginalized.

Mutiara

"Dukuns are more accessible and affordable in the inlands of Central Lombok"

Mutiara, 35 years old, lives in Rancak village, 3 km from the Praya subdistrict center in Central Lombok. Her house was difficult to find because it

was located in a remote area. The area was filthy. Stables for cows, horses and chicken were everywhere and located very close to residences. The houses were very close to each other and separated only by narrow yards.

Mutiara has three children. The oldest is in 7th grade, the middle child is in elementary school, and the youngest is not even three years old. Mutiara has been pregnant four times, but one pregnancy ended in a miscarriage.

During her first pregnancy, Mutiara did not know that she was pregnant. She continued her daily activities as usual. One day, she had intense abdominal pain accompanied by fever. After two days, her husband took her to the *puskesmas* in Praya. After examining her, the health worker on duty at the *puskesmas* administered an injection and gave her some medicine to drink. That night, Mutiara was shocked to see vaginal bleeding. Because she was so frightened, Mutiara's husband asked a *dukun* to examine her. The *dukun* massaged parts of Mutiara's abdomen and told her that she was three months pregnant, but the fetus had already died. It was only then that Mutiara realized that she was pregnant. The health worker in the *puskesmas* did not say anything about her being pregnant. The *dukun* massaged her abdomen for about one hour until the fetus came out. After that, the bleeding stopped.

Although Mutiara realized that *bidans* have better equipment, she trusted *dukuns*. She said that it cost more than Rp. 100,000 to give birth with the assistance of a *bidan*, even though it should be free. The *bidan* did not say that the delivery was free and she accepted payments whenever they were offered. Mutiara would be embarrassed if she didn't offer payment to the *bidan*.

Each time after giving birth, Mutiara experienced an unusual amount of vaginal discharge and abdominal pain, and her chest swell painfully. To treat her pain, she bought herbal drinks from a *dukun* in another village. According to her neighbors, the traditional medicines were very effective for postpartum pain. The herbal medicine cost Rp. 10,000 per package and she took it regularly until her vaginal discharges and pains subsided.

Developing a Partnership with *Dukuns*

The maternal mortality rate is related to the availability of adequate health facilities, access to those health services, the quality of childbirth assistance, and the referral mechanism when there is a problem in childbirth. This chapter will discuss the availability of childbirth assistants in the society. Currently, there are two categories of childbirth attendants: medical personnel, i.e., medical doctors and *bidans* who have the basic knowledge and skills to assist in childbirth by applying standard methods, and non-medical personnel, i.e., *dukuns*, who use traditional methods in providing health services and childbirth assistance. These two kinds of childbirth assistants co-exist in the society and each serves their own segment of the population.

The research results shown in Table 5.1. indicate that in the seven research areas *dukuns* still played an important role in assisting childbirth, except in the city of Surakarta that has a well-developed urban infrastructure that allows residents to easily access health service facilities. Meanwhile, in Jembrana, the Jembrana Health Insurance (JKJ) policy makes it easier and less expensive for women to access doctors for childbirth assistance. Similarly, in Central Lombok and Indramayu, the policy to provide free childbirth assistance also makes it easier for poor women to access services provided by *bidans*. Compared to other areas, such as Lebak, North Lampung and West Sumba, the provision of free childbirth services and cultural traditions, and the relatively better geographic conditions and easier access to transportation in Jembrana, Central Lombok

Table 5.1.
Childbirth Attendants in the Seven Research Areas

No.	Childbirth Attendents	Lebak (%)	North Lampung (%)	West Sumba (%)	Surakarta (%)	Jembrana (%)	Central Lombok (%)	Indramayu (%)
1.	Doctor	2.3	3.0	3.3	35.3	21.0	7.0	9.0
2.	*Bidan*	21.3	55.3	54.7	62.7	64.3	74.3	78.7
3.	*Dukun*/Other	76.3	41.7	41.7	2.0	14.6	18.7	12.3

and Indramayu make it easier for the residents to access childbirth services provided by *bidans*.

In West Sumba, cultural traditions and the difficulty of accessing *bidans* because of geographic conditions caused 41.7% of women in the district to ask *dukuns* for assistance in childbirth. In North Lampung, data from the Human Development Report shows that the number of non-medical assistance in childbirth in 2004 came to 48.8% or almost half of the total number of childbirths. In fact, even when complications occured, 80.8% of women in West Sumba still chose to have a *dukun* assist them in childbirth because the *dukun* usually lived close by and did not set fees for her services. The patients and their families determined how much they would pay the *dukun* based on their own capabilities and willingness. It is for these reasons that *dukuns* are preferred over other health workers.

The society's trust in the *dukuns* is a cultural heritage that has been passed down through generations. Women are often encouraged by their parents and parents-in-law to ask *dukuns* for assistance, as shown in the following story:

> "A *dukun* helped me when I gave birth. When I went into labor, my mother-in-law told my husband to get the *dukun*. So, I was helped by a *dukun*. If a *bidan* had been called, I wouldn't have been able to pay her because they say that *bidans* are expensive. I don't know how much, but people say that it's expensive to ask a *bidan* to help."

Farida
Ketare village, Central Lombok

Poor Women Choose a Dukun to Assist them in Childbirth

Farida, 40 years old, is from a poor family that works as free-lance farm laborers. As they are free-lance laborers, Farida and her husband do not have regular work every day. Since most of the land in the southern part of Central Lombok do not have irrigation and only produces rice once

every year, the remaining ground water is used for corn, peanuts or melons. The rest of the land is out suitable for planting. This means that Farida and her husband work primarily during the planting and harvest seasons.

Farida has six children. At the time of the interview she was still nursing her youngest child who is nine months old. Farida said that she had been pregnant eight times. One child died at the age of 50 days and another one died in the womb. Seven of her eight pregnancies and births were attended by the *dukun* in her hamlet. Only the last child was born at the *puskesmas*. Although the service at the *puskesmas* was free, there were other expenses, such as transportation and meals while at the *puskesmas*, that made this birth more expensive than the others. Because of this, Farida no longer wanted to give birth at the *puskesmas*. According to Farida, she had many children because she could not afford to pay for the contraceptive injections that cost Rp. 15,000. She would rather spend the money on food for her family.

Farida suffered a miscarriage in her fourth pregnancy. She experienced heavy hemorrhaging for one week and she could not walk for two days because of extreme pain in her vaginal area. Although she was suffering and bleeding, she still had to wash her own soiled clothes and sheets, and cook for her husband and children.

During one pregnancy, Farida was extremely nauseous for the entire day and night. She felt terrible pain in her abdomen. A *dukun* was called to assist her, and she told Farida to deliver the baby in a sitting position to make the delivery faster. After many contractions, the baby was born into the *dukun*'s bare hands. The *dukun* cut the umbilical cord with a bamboo knife (*adas-adas*, in Sasak) made from a slat taken from the wall of Farida's house and sharpened. Then the *dukun* placed a peppercorn on the baby's navel so that it would heal quickly. If the umbilical cord became infected, the *dukun* usually instructed the mother to place ashes from the cookstove onto the dried umbilical cord. According to the *dukun*, the ashes would dry the cord and heal it.

After the delivery, Farida experienced heavy postpartum bleeding, soaking through more than three cloths a day for seven days. She had extreme pain and cramps and could not walk for three days. She suffered

from high fever for two days and had several other problems, such as swollen breasts and a fetid smell from her vagina.

There were no *bidans* in Ketare village. The closest health facility that Farida could reach was the *puskesmas* in Sengkol, which was approximately 7 km from her village. The distance from her house to the main village road was about 3 km. She had to either walk or hire an *ojek* for Rp. 5,000 to reach the main road to get to a public transportation, which cost Rp. 2,500, to go to the *puskesmas*. This meant that Farida would have to spend Rp. 15,000 for a round trip to the *puskesmas*, which was more than her daily wages as a farm laborer. Her daily wages came to Rp 10,000, while her husband got Rp. 15,000 each day. It was unlikely that she would spend that amount on transportation to a health facility. She would rather use the money to feed her family.

After the delivery the *dukun* treated Farida as follows:

First, in order to shrink the vagina, Farida was told to heat a stone. The hot stone was then wrapped in a baby diaper and used to warm her body. This treatment was also applied to her vagina.

Second, in order to heal her vagina, Farida bathed in water that was filled with spices and herbs. After bathing, Farida sat on a hot stone that had been laid in the sun (between 11 a.m. to 12 noon). When she sat on the stone, Farida's vagina had to touch the hot stone to quicken the healing process.

Third, in order to restore the body's health, the *dukun* made a traditional medicine for Farida that consisted of palm sugar and pepper. This concoction was to be taken until she recovered. If her body rejected the *jamu*, she could suffer from diarrhea.

Fourth, in order to eliminate the smell of her vagina, Farida boiled water in a medium-sized metal bowl over the cookstove. When the water boiled, the bowl was placed below her vagina. Although the hot steam on her vagina was very painful, it was effective in eliminating the unpleasant odor.

Farida said that people believed that women should not eat chicken after they gave birth because it would make the baby's body as hot as the chicken's body. The belief was that the mother should not eat chicken until the baby was six months old.

Ninuk Widyantoro[1] thinks that we cannot dismiss the role of *dukuns* in the community. *Dukuns* provide health services, especially to the impoverished, who cannot access health service facilities because of the distance and their inability to pay for transportation. *Dukuns* are the main childbirth attendants in poor and remote areas. WRI research results show that *dukuns* live in the villages, and in North Lampung there were at least four or five *dukuns* in one village. They are on call 24-hours a day. This is why it is easier for villagers to contact *dukuns* for assistance. They do not have to spend extra money for transportation and *dukun's* fees are relatively inexpensive in comparison to those of other health workers.

According to Roy Tjiong[2], although there are disadvantages in having a *dukun* assist in childbirth, there are advantages that must be acknowledged. *Dukuns* are usually older women who have more experience in attending childbirth than young *bidans* who have just graduated with a D1 or D3 certificate. D*ukuns* are usually very patient and more attentive in assisting childbirth. The kinds of services a *dukun* provides are more complete, beginning with pregnancy control, childbirth and extending to postpartum care. The results of WRI research show that for pregnancy care, the *dukun* massages the pregnant woman's abdomen to make sure that the baby's position is normal so that the birth process will be unhampered. If a doctor or *bidan* finds that the position of their baby is not normal, usually the women ask a *dukun* to rotate the baby's position to a normal one in order to avoid complications that would require extra payments during childbirth. The women felt that the *dukun*'s ability to move the baby's position in the womb was a skill that medical personnel, i.e., doctors and *bidans*, did not have. *Dukuns* usually massage patients when they are one month, five months and seven months pregnant. One massage costs between Rp. 15,000 to Rp. 25,000, depending on how well-known the *dukun* is.

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[1] WRI Research, *Akses dan Pemanfaatan Fasilitas Pelayanan Kesehatan Reproduksi bagi Perempuan Miskin di tujuh wilayah Penelitian*, 2007-2008.

[2] *Ibid.*

Each *dukun* has her own special methods of providing childbirth assistance, but usually they begin with preparing equipment and herbal treatments. Mbah Girah from Hanakau Jaya village in North Lampung; always started the process by asking her patient to drink water that she had prayed over. Then she placed tumeric on a piece of sharp bamboo, called *ulat*, which she would use to cut the umbilical cord. She believed that turmeric was a natural antibiotic. She crushed betel leaves and wrapped them in a whole betel leaf that was placed on the vagina to reduce swelling and quicken recovery after the delivery. She also boiled some betel leaves and gave the water to the women right after childbirth. There are *dukuns* who used uncommon methods, such as spraying the vagina with alchohol to kill bacteria and help heal the wounds. Of course, this method causes extreme pain. Meanwhile, Mbah Yat in the Kotabumi Ilir subdistrict in North Lampung had special techniques to treat lengthy labors. She instructed her patients to chew nutmeg and then swallow it to help speed up the birthing process. According to Mbah Yat, this treatment was more effective and safer than inducing labor by injection.

Dukuns are usually very patient and careful in attending mothers in labor. They are willing to wait for hours until the baby is born. It is rare that women who have been attended by a *dukun* suffer from tears that require stitches because the *dukun* is patient in motivating them to give birth naturally and safely. After the baby is born, the *dukun* bathes both the mother and the infant, and sometimes also helps to wash the soiled clothes and sheets.

Usually, the *dukun* does not set specific fees for her services. The patients pay for her assistance according to their capabilities. Some pay Rp. 50,000 to Rp. 250,000, while some others do not pay anything because they cannot afford to. If they don't get paid, usually *dukuns* accept the circumstances and they will still visit the patient, nurse her and bathe the baby until the umbilical cord falls off. *Dukuns* also massage the mother to restore her strength and raise her stamina so that she will recover quickly. The baby is also massaged routinely so that it will sleep well and grow normally. The *dukun* visits the mother and newborn baby every day for

two weeks to one month to make sure that the patient recovers well. She will also massage the mother on the 40th day after birth to restore the uterus to its normal position. This massage is called *walik dadah*. The *dukun* does not ask for extra payment for these postpartum visits. However, she will not refuse gifts and tips as an expression of gratitude. It is difficult for a doctor or a *bidan* to compete with the *dukun* in offering these kinds of services.

Several respondents stated that they trusted *dukuns* because of their experience, age and powerful prayers. *Dukuns* provide services in accordance to local traditions and many of them are believed to have mystical skills and abilities to make traditional herbal treatments. For example, Mbah Kasiyem from Negara Ratu village in North Lampung was believed by the local community to have super-natural powers. She had an enchanted stone called *Batu Wali Songo* that they believed, had the power to heal various diseases. Mbah Kasiyem claimed that the stone embodied a spirit that that lived in the tomb of one of the Wali Songo (nine legendary Muslim preachers who spread Islam throughout Java) and controlled the river in her village. To ease the birth process, Mbah Kasiyem usually made the mother drink water in which the *Wali Songo* stone had been soaked. In West Sumba, several *dukuns* made women drink a *jamu* made from a mixture of roots to reduce pain during labor. Traditional drinks were also given to the women if they were in pain after the delivery.

Ita, a *dukun* who lived in Cempedak subdistrict in North Lampung, had a different method of treating expectant mothers. She dried the placenta of newborn kittens, boiled it, and gave the water to the women in labor to drink to quicken contractions and the birthing process. She then dried out the placenta and stored it away for the next patient. There are also *dukuns* who used tea made of *fatimah* grass (dry black grass imported from the Middle East) that is used to hasten contractions and ease the birthing process. The belief that *dukuns* have mystical powers and abilities to apply traditional treatments can be found in Central Lombok, Indramayu, North Lampung, and Lebak.

Although these beliefs provide psychological assurance to the patients.

Widyantoro and Tjiong agree that *dukuns* do not have formal training in midwivery. Many of the *dukuns* in the research areas said that they inherited their skills from their mothers who took them along when they assisted women in childbirth. Children of *dukuns* learned their skills by observing and assisting their mothers. There were also *dukuns* who claimed that they aquired their healing skills through a mystical process by undergoing various spiritual exercises. It should also be noted that *dukuns* used various kinds of tools, such as metal or bamboo knives to cut the umbilical cord. These tools are not sterilized and are used in places that do not fulfill the minimum health standards of the World Health Organization.

Salsabilah

Askeskin does not help to encourage mothers to give birth in health facilities

Salsabilah, 40 years old, is the eighth of ten siblings. She attended elementary school through the second grade, but was forced to drop out because her parents could not afford to keep her in school. At the age of 16, not long after her first menstruation, Salsabilah married Ahmad Toni, who was one year older. Marriage at a young age was not unusual in her family, and it is a common practice in the region where the first menstruation is interpreted as a sign that the girl is ready for marriage. Marrying their daughters at a young age reduces the economic burden of the family.

One year later, Salsabilah gave birth to her first child. She was 17 years old. Salsabilah works variety of jobs, such as washing clothes, cutting grass, cleaning house, etc. Her husband, Ahmad Toni, also does odd jobs, such as digging wells, chopping down trees, etc. They do not have fixed monthly incomes. Sometimes they earn Rp. 200,000, but it is not unusual that they do not earn anything during an entire month.

At the present time, Salsbilah has nine children – five girls and four boys. Three of the nine children were born with the assistance of a *dukun*, one with a *bidan*, and she gave birth to the other five by herself with her husband's help. Only after the baby was born would they call either a *bidan*

or a *dukun* to cut the umbilical cord and bathe the newborn baby. They did this to save expenses. Normally, the fee for a *dukun* was about Rp. 150,000 and for a *bidan* was about Rp. 350,000. By giving birth herself, Salsabilah spent only Rp. 50,000 for a *dukun*, or Rp. 100,000 for a *bidan* to bathe the baby and administer an injection and medicines.

Salsabilah said that she and her family rarely went to the health service facility, i.e., the *puskesmas* or *bidan*, because they didn't have money. Besides that, she once had an unpleasant experience when she used her Askeskin card at the *puskesmas*. She felt that she was ignored, belittled, neglected, and not treated well because the *puskesmas* attendant was unfriendly to Askeskin cardholders.

Salsabilah and her husband said that they had not enjoyed the benefits of using the Askeskin insurance provided by the government. Based on their experiences, there was no health service that was truly free, even with the Askeskin facilities. *"Without money, you don't get any health services."* They said that they bought medicines only when they had money. If they could not afford it, they treated themselves with medicines they bought at the local food stalls.

When Salsabilah took her youngest child to the *puskesmas* for immunizations, she found out that the service was not entirely free. She had to pay a minimum of Rp. 1,000 for each immunization. If she did not, the *puskesmas* attendant would not immunize her child. She said after she paid, the *puskesmas* denied her child the food supplements for infants because her three-year old child was no longer considered to be a baby.

Salsabilah had another disappointing experience with Askeskin when she sought treatment for her second child who was suffering severe talassemia. The Askeskin card only provided for a free room, doctors' services and medicines that were available at the hospital. However, treatment for a disease such as talassemia, which might require blood transfusions, was not free. For each blood transfusion, Salsabilah had to buy blood from the Indonesian Red Cross (PMI) for Rp. 60,000 per bag. It was very expensive for her because each treatment required four bags, meaning that she had to pay Rp. 240,000 for each blood transfusion which had to be performed as often as two or three times every month. The burden was worse if the stock of blood at PMI was low, then Salsabilah

had to pay Rp. 100,000 per bag. Her child eventually died because he did not receive adequate care. Before the child died, he was hospitalized for about one month. The hospital expenses amounted to Rp. 1,500,000, plus the costs of transportation and food for the family who took care of him at the hospital. Salsabilah and her husband hope that there will be a government policy that actually covers all medical treatments for the poor.

In some cases, *dukuns* engage in cultural traditions that endanger the lives of women who suffer hemorrhaging before, during and after childbirth. In West Sumba, there is a traditional ceremony conducted for women suffering from heavy bleeding resulting from complications in childbirth.[3] The local cultural leaders call the *dukun* and together they ceremonially butcher a chicken, buffalo or pig. They immediately examine the heart of the butchered animal. If the heart is bright red or in a good condition, then they believe that the woman will be safe during the childbirth process. If, however, the animal heart is black or in a poor condition, then they believe that she will need help during labor, and only then will they attempt to contact a *bidan* to assist with the difficult childbirth. Often, efforts to save the woman's life are too late because the woman continues to hemorrhage during the ceremony.

The cultural practice of *rembugan*, or 'discussion', in Lebak is similar to this ceremony in West Sumba. If a woman is experiencing heavy bleeding, she cannot immediately access medical assistance because the family must gather to discuss the situation. This traditional practice, called *rembugan*, requires considerable time because all members of the family, even those who may live far away, must be invited to participate in the family discussion to make a decision. This process is important especially if there are expenses involved, as the entire family will share in coverin

[3] Interview with Leni Marlina Puling, a *bidan* in Gaura village, Lamboya subdistrict, West Sumba, December 18, 2009.

the expenses. It is not rare that a woman will die during this lengthy process. In regards to this practice, the Director of IBI and the Mothers' Health Division in the district of Lebak said:

> "The practice of family *rembugan* takes a long time and it might result in negative consequences in an emergency situation. Since the husband could not pay for the childbirth expenses, he could not make any decisions about his wife's treatment. Therefore, he had to rely on the *rembugan* process with other members of the family. These kinds of emergency situations happen frequently in Lebak. Many of the delays in childbirth assistance are caused by economic predicaments."[4]

According to Widyantoro and Tjiong, *dukuns* should assist only in childbirths that are proceeding normally without any difficulties or complications. The combination of the high risks of childbirth and the limited knowledge and skills of the *dukun* contribute significantly to the high MMR. WRI research also shows that the antiquated knowledge of the *dukun* limits their effectiveness in educating women who believe in local myths that are detrimental to their health. Many women in Indramayu believe that pregnant women may not eat foods that are high in protein, such as saltwater fish, squid and shrimps because their babies will be born late or their bodies will be curved like a shrimp. When they are nursing, they believe that they may not eat any kind of fish, especially saltwater fish, eggs, and vegetables cooked in a sauce, and may only eat tempeh, which is made from soybeans, that has been boiled without any spices or flavoring, so that their stitches will dry quickly. After giving birth, they believe that sleeping during the day will cause their blood to rise to their eyes and result in blurred vision. One respondent spoke about these taboos:

[4] Interview with the Director of IBI and the Mothers' Health Division in Lebak, April 2008.

> "I only ate boiled tempeh for 40 days after giving birth; and it made me feel very weak. Usually, women follow these food taboos because their parents force them to. They say it is for the child's benefit, even though they feel weak and bored with the food."

Dukuns do not provide information about family planning. They encourage the belief that "many children means much fortune", meaning that each child brings its own good fortune. One respondent in Lebak[5] said:

> "I have many children, but what can I do? I just accept it. Don't they say that good fortune is in the hands of God? And children bring their own good fortune."

Dukuns do not have the knowledge to change the perceptions of the society. They cannot prove that having many children is detrimental to the mother's health. In the rural areas of Lebak, there are many women who have more than six children and some have more than 12 children. *Dukuns* are also incapable of teaching women about complications in childbirth. WRI research results show that the majority of women, both in the urban and rural areas, do not know about the conditions that can increase risks in pregnancy and childbirth. Because of this, pregnant

Table 5.2.
Percentage of Pregnant Women in Central Lombok who Experienced Complications in Pregnancy

No.	Complications in Pregnancy	Central Lombok
1.	Nauseous for 9 months	40.7
2.	Bleeding	4.7
3.	High fever	24.0
4.	Seizures and fainting	6.7
5.	Experience one of the above	51.0

[5] Interview with a respondent in Cikarang village, Muncang subdistrict, Lebak, April 2008.

women cannot conduct early detection of various potential complications during their pregnancies and labor.

Table 5.2. shows that 51% of the respondents in Central Lombok experienced at least one of the four listed symptoms. Approximately 72.3% of the women in the district did not know anything about complications or potential dangers during pregnancy. About 43% of pregnant women in Central Lombok were not examined during their pregnancies, even though they experienced at least one of the symptoms of complications either during their pregnancy, labor or in the postpartum period. As one pregnant mother who experienced complications in Ketare village said:

> "I don't have any money to pay for a health examination, and I am used to this. I can endure the pain."[6]

Table 5.3.
Complications in Pregnancy in Central Lombok, 2005

No.	Risks	Referral Cases for High Risk Pregnancies		
		2003	2004	2005
1.	Estimated Pregnant Women	21,450	21,450	21,450
2.	Estimated High Risk pregnancies (20%)	4,290	4,290	4,290
3.	% of Cases Treated	9.18%	8.33%	9.50%
4.	Hemorrhaging	1,034	918	1.006
5.	Infection	72	49	55
6.	Eclampsia	198	155	178
7.	Lengthy Labor	364	414	449
8.	Others	304	255	375
	Total Cases	1,972	1,791	2,045

Source: Department of Health, Central Lombok.

Because *dukun*s have limited capabilities, special effort is needed to improve their knowledge and skills so that they can assist normal deliveries in accordance to standard childbirth medical practices. Widyantoro suggests forming a partnership between *dukuns* and *bidans* in which the *dukuns* will no longer serve as the primary childbirth attendants. Mbah

[6] Interview with Marian, from Embung Rungkas hamlet, Ketare village, April 19, 2007.

Marto, an 80-year old *dukun*,[7] spoke of one such partnership. In the 1990s, Mbah Marto received training and equipment from the local *puskesmas* to improve her services for attending childbirth. The *puskesmas* gave her scissors, a surgical knife, alchohol, and equipment for sterilizing tools, as well as basic medicine for postpartum recovery, including paracetamol. The *bidan* from the *puskesmas* maintained routine communications with her and regularly invited her to meetings with other *bidans* and IBI. In this way, the *puskesmas* was informed of Mbah Marto's activities in assisting pregnant women in her area and was ready to help in emergency situations.

At the present, Mbah Marto no longer assists in childbirths, but specializes in massaging babies. However, she is still often asked to massage women who have just given birth to restore the health of their uterus. There are also women who come to her because they are experiencing postpartum difficulties, such as hemorrhaging. They believe that they will recover if Mbah Marto massages them. Many women who live nearby also bring their babies to Mbah Marto to be massaged when the baby has a fever, is cranky or has recently fallen. The patients pay Mbah Marto whatever they can afford. Sometimes Mbah Marto does not ask for payment if the patient is truly unable to pay.

Bidans should Become an Effective Spearheads

If the *bidan* is assigned to work only at the *puskesmas* at the subdistrict center or opens a private practice in her home in the urban or town centers, she will not become an effective spearhead in the effort to reduce the MMR because she will not be able to reach the most remote areas that are the pockets of high maternal mortality. The *bidan* will become effective only if she lives at the *polindes*, is active in the *posyandu* and establishes close relationships with the *dukuns* in the villages in her area.

[7] Interview with Mbah Marto in her house in Sangkrah subdistrict, August 15, 2007.

Table 5.4.
Factors that Influence the Choice of a *Dukun* to Assist in Childbirth in the Seven Research Areas

Reasons for choosing a *dukun*	Reasons for not choosing a *dukun*
1. *Dukuns* are easily accessed since they live near the people who need their services. 2. *Dukuns* are willing to make house visits wherever and whenever needed. 3. *Dukuns* are flexible in terms of payment, adjusting to the capabilities of the patient. 4. *Dukuns* provide services in accordance with local traditions, such as making traditional remedies and praying over them. 5. *Dukuns* have beliefs and practices that have been handed down over generations. 6. *Dukuns* are very patient, attentive and calming. 7. *Dukuns* can always be consulted when the *bidan* is not available at her home or at the *polindes*, or is on vacation. 8. *Dukuns* have close emotional relationships with the patients because they may be neighbors or relatives, so it is easier for the patient to relate her health problems to the *dukun*. 9. *Dukuns* provide care for the newborn baby and the mother for 40 days after birth, and participate in the ritual ceremony celebrating the infant's first month. 10. *Dukuns* are older and trusted by the local community to be able to cure various health problems and illnesses. 11. The local community believes that there are illnesses that are not physically based (caused by spirits), and these illnesses can be treated by the *dukun*.	1. The patient has high-risk pregnancy and childbirth. 2. Health promotion campaigns by health workers and assistants through *posyandu* that pregnant women should go the *puskesmas* to a medical personnel for pregnancy exams and childbirth. 3. Availability of free services from the *bidan* for JKJ and Askeskin members. 4. Increasing number of *bidans* who are assigned to the villages and are available 24 hours (in Surakarta, Jembrana). 5. The *dukun* is worried that she might be sanctioned by the local government if any problems occur in a childbirth she is attending.

Indah

Gerunung ward, Praya subdistrict, Central Lombok

The Dukun is Consulted because the Bidan is Not Available

When we met her village in Kesambi Numpuk in Gerunung, Indah, 21 years old, said that she still resided with her parents-in-law, where she and her husband and their child lived in one bedroom. She said that her parents-in-law helped them out with many of their household needs. Her husband worked as a free-lance day laborer and received Rp. 7,000 per day. During the harvest season he was paid with 25 kg of rice per day. When there is no work, Indah and her husband often planted or harvested the small rice field that her parents-in-law owned and were paid one bag of rice at harvest time.

Indah got married when she was 18 years old. It is not unusual for girls in her village to be married at that age, and there were some who were younger than her when they got married. Some members of the society in Central Lombok felt that it was alright for young women of Indah's age to be married and have a family, although they did not have decent jobs.

Because they were classified as impoverished, they received Askeskin cards from the village officials, and they often used them when they were ill. However, it was still difficult for Indah to access the health facilities. She had to pay for the *ojek* since she lived 2 km away from both the *pustu* and the *puskesmas* and the road was not in good condition. Often Indah just bought medicines at the local foodstall, which was much cheaper than going to the nearest *pustu*.

Indah's mother-in-law was a *dukun* who assisted in childbirths in the Kesambi Numpuk area. Ever since there had been a *bidan* in the Gerunung subdistrict, her mother-in-law had been invited to work with the *bidan* and accompany her to deliver babies in her house. When Indah was pregnant, she was examined by her mother-in-law and rarely went to the *bidan*. However, when she went into labor, her mother-in-law took her to the *bidan*'s house, which was about 2 km away from their home. Unfortu-

nately, the *bidan* was not there because she had left to go to her family's home. So, Indah and her mother-in-law returned to their home and she gave birth there. Indah felt comfortable being attended by her mother-in-law, even though the labor was difficult and long because she had felt nauseous for several days. However, her mother-in-law was patient and she massaged her abdomen to reduce the pain. Two days after she gave birth, the *bidan* visited her and administered an injection. Since then, Indah has never gone to the *bidan* for any examinations. She prefers her mother-in-law's care.

Since there are many remote villages in West Sumba, distance to health service facilities, the time that it takes to get to there, and the expenses incurred influence women to choose to go to the *posyandu* and *polindes* in their own areas rather than travel to the *puskesmas* in the subdistrict centers, even though the services at the *posyandu* and *polindes* are limited. The number of women patients visiting several *posyandus* in the Waikabubak and Kabukarudi subdistricts came to around 50-150 people every day, and about 10% - 50% of them were there for pregnancy exams. Only 17.5% of pregnant women went to the *puskesmas*, or consulted a *bidan* or doctor. The majority of pregnant women in Indramayu also chose to have their pregnancy exams at the *posyandu* because it was easy to access and they had a close emotional bond with the *bidan*. Several *posyandus* in the subdistrict collected between Rp. 300 to Rp. 1,000 from every patient and used the money to buy eggs and milk for the *posyandu* patients.

Since many *polindes* are not yet suitable for residence and for providing services, the reduction of the MMR requires a partnership between *bidans* and the *dukuns*. *Dukuns* must be seen as potential partners for *bidans*. Successful partnerships have been established between *bidans* and *dukuns* and these partnerships should be studied for replication to other areas.

There are various *bidan-dukun* partnership strategies that can be promoted. **First**, the Health Department provides training to improve the knowledge and skills of *dukuns*. This program has been conducted peri-

odically in Indramayu, Lebak, Jembrana, and North Lampung. Every *dukun* in the district is required by the Health Department to participate in the training program. In Indramayu, every *dukun* that participates in the training program receives Rp. 20,000 to Rp. 25,000. The materials presented in the training include:

a. How to use equipment for childbirth assistance;
b. How to care for pregnant women;
c. Information about pregnant women and women in labor;
d. Information about danger signs in women in labor;
e. Methods for a sterile childbirth;
f. How to care for the umbilical cord;
g. How to bathe and take care of the newborn baby;
h. How to provide information to pregnant women to have a tetanus (TT) shot;
i. Information about tetanus;
j. Information about birth certificates.

Every *dukun* that has participated in this training program is given a complete set of equipment and medicines for assisting in childbirth. The package includes scissors, cloth bandages, a container for the placenta, gloves, betadine, painkillers, and antibiotics to be used to prevent infections in mothers who have just given birth. The *dukuns* have been using the equipment and medicines and they report to the coordinating *bidan* at the *puskesmas* when they need more medicine.

The **second** partnership strategy involves supervision and monitoring. This strategy is applied in North Lampung. The local government maintains close supervision on the practices of *dukuns* in assisting childbirth through *bidans* at the *puskesmas*. The first step taken by the local government is to document *dukuns* living in the area and classify them according to their experiences. The monitoring includes documentation of the cases of live births and deaths handled by *dukuns*, and how they handled each case.

The **third** strategy is to establish a routine forum for *dukuns*. In North Lampung, the coordinating *bidan* in the Kotabumi area gathers all *dukuns*

for a meeting on the fifth day of every month at her house for a training session to improve their knowledge and skills. However, it is not easy to convince the *dukuns* to attend these training sessions. Besides the fact that many of the *dukuns* are elderly, the distance they must travel to reach the meeting place is often a hindrance for them to attend monthly sessions routinely. At these meetings, it is suggested that *dukuns* form a partnership with the nearest *bidans* to provide childbirth assistance together. A *dukun* is encouraged to call a *bidan* when a mother goes into labor. The *bidan* is also encouraged to enlist the help of the *dukun* in the childbirth process, which will gradually decrease in the future. *Dukuns* will be directed to focus more on providing care for the newborn infants.

Incentives and/or Sanctions

The Health Departments in Indramayu, Lebak, Jembrana, North Lampung, Central Lombok, and West Sumba have introduced policies to provide incentives to *dukuns* and *bidans* who are willing to form partnerships. These incentives vary between the regions. In Indramayu, if a *dukun* calls a *bidan* to assist in childbirth, she will receive an incentive of Rp. 50,000. However, there is also a sanction of Rp. 50,000 if the *dukun* attends childbirth without calling a *bidan*.

In Central Lombok, a *dukun* receives Rp. 25,000 for every patient that she brings to a health facility or medical worker. According to one *bidan*, if a *dukun* provides assistance in childbirth, the *bidan* will pay her Rp. 25,000 out of her own personal funds. She will then process a claim to PT Askes for reimbursement along with a claim for the childbirth fee. However, it appears that this system does not yet work smoothly. In the Praya village, for instance, *dukuns* that take their patients to the *puskesmas* rarely receive any compensation.[8] As a result, several *dukuns* do not participate in this program and handle the childbirths themselves.

[8] Interview with Inaq Kinah, a *dukun* in Praya, August 21, 2007.

In North Lampung, *dukuns* are encouraged to call a *bidan* to deliver babies, while *bidans* are encouraged to involve *dukuns* as their assistants. The payment received from the patient is shared between the *bidan* and the *dukun*, with the *bidan* receiving bigger share than the *dukun*. One *dukun* in the Cempedak region said that she received an incentive from Rp. 50,000 to Rp. 150,000 for helping the bidan in providing childbirth assistance. A partnership between *dukuns* and *bidans* will minimalize the risks in the birth process that endanger mothers.

The political will of the local government of Takalar district in South Sulawesi in developing a partnership between *dukuns* and *bidans* is examplary. Approval from the local legislature on January 29, 2010 made Takalar become the first district in Indonesia to introduce a Local Regulation concerning the partnership between *bidans* and *dukuns*. This partnership program was initiated in 2007 when the Takalar district government, along with the United Nations Children and Education Fund (UNICEF), piloted a training program for the partnership between *bidans* and *dukuns* in two subdistricts, Galesong and Polombangkeng Utara. Since the partnership program is institutionalized through a Local Bylaw to be implemented district wide, the local administration provides a special fund from the APBD, which is adjusted in accordance to the requests from *bidans*.[9] A meeting attended by 32 *dukuns* and 50 *bidans* produced a joint agreement that divided the tasks between the two groups. *Dukuns* will assist *bidans* for the entire process of caring for the mothers from pregnancy through childbirth. A *dukun* will receive an incentive of Rp. 50,000 for every mother that she brings to the *puskesmas* to give birth. According to the Director of the Health Department in Takalar, Dr. Grace V. Dumalang, the implementation of the partnership had been able to contribute to the reduction of maternal death from eight in 2006, to three in 2007, to one in 2008, and to zero in 2009. The role of the government in introducing a policy and budget allocation is vital for the success of reducing the MMR through a *bidan-dukun* partnership.

[9] *Kompas* newspaper, February 1, 2010.

Meanwhile, the local government in West Sumba, in addition to providing incentives to *dukuns* and *bidans* who are willing to join in partnerships, has applied a policy that deserves to be replicated. The local government uses Askeskin to provide free services for childbirth at the *polindes* or *puskesmas*. Patients could still give additional payments to a *bidan* in kind, not in cash, in the form of cloth or a chicken, as an expression of gratitude. The *bidan* is often not able to refuse these gifts, as it would appear that she does not appreciate the offer. The serious intent of the local governments in the districts of Takalar, Indramayu, Lebak, Jembrana, North Lampung, Central Lombok, and West Sumba to encourage the partnership between *bidans* and *dukuns*, and to provide free childbirth services must be replicated in other districts.

Lestari

Pekandangan Jaya village, Indramayu Ayu ward, Indramayu

Lestari, 35 years old, is the oldest of six children, two of whom have died. Lestari's mother was married six times and all of the marriages ended in a divorce after an average of one or two years. Lestari said that she didn't know her father very well because she was raised only by her mother. She only remembered that there were men who befriended her mother and left her with children. She did not know whether her mother ever married any of those men formally or through religious acknowledgement (*nikah siri*). Lestari's mother had a child from each of these men, so Lestari has two younger brothers and two younger sisters, each with a different father. Lestari was the only child who stayed with her mother.

After finishing elementary school, Lestari began to work to support her family. She started working to wash clothes and clean houses and eventually became a migrant worker when she was 13 years old. Her uncle and her mother's family urged her to work abroad to help support the family and renovate their house that was falling down. Lestari's uncle

sent her to work in Saudi Arabia as a maid for four months. Every month she received wages of Rp. 600,000. She did not continue this work for long because she did not feel strong enough and became very homesick. When she returned home from Saudi Arabia, Lestari had difficulties in finding a job because of her limited formal education. Therefore, she accepted an offer to work as a maid in Batam. However, when she arrived in Batam, she realized that she had been deceived and was forced to serve as a sex worker. She was not able to refuse because she had to repay a debt for her ticket to Batam, which cost Rp. 2 million. Lestari was forced to work as a sex worker for two months to collect the money to repay the debt, then she returned home to Indramayu.

While she worked as a sex worker in Batam, Lestari experienced unusual vaginal discharges, inflammation and itchiness in her vaginal area, but she never went to a health facility for a medical examination. To treat her symptoms, she just bought aspirin, got a massage, bought or made *jamu* from a mixture of galingale root and tumeric, and bought antibiotics at the local store. After returning to Indramayu, Lestari engaged in relationships and lived with different men. Her current boyfriend is a broker who looked for women who were willing to become sex workers. Lestari received financial help from her boyfriend to help her support her mother. Not one of Lestari's boyfriends was willing to marry her although she had been pregnant twice.

During her first pregnancy, Lestari consulted a *bidan* three times. She also went to a *dukun* twice to be massaged to maneuver the fetus into a normal position when she was two months and five months pregnant. The massage was painful because the *dukun* pressed firmly down on her abdomen, but she did it because her mother and family recommended it. Throughout her pregnancy, Lestari often fell down because she was anemic, and the *bidan* gave her medicine for iron deficiency. She suffered headaches, felt very weak and slipped easily.

When she went into labor, Lestari asked her neighbor to call the *bidan* to her house to help with the birth. The delivery was very difficult and Lestari was in extreme pain. The *bidan* who attended the birth became impatient and confused. She applied one liter of cooking oil to Lestari's

vagina because the fetus would not come out even after Lestari had been in labor for 24 hours. She became too weak to push during the contractions. They did not know why there were difficulties with the birth. During the pregnancy examinations, the *bidan* said that the pregnancy was normal.

Finally, the *bidan* applied pressure to Lestari's abdomen. She asked for several other people to help her press down on Lestari's abdomen to push the baby out. Five men helped the *bidan*. They held her feet, torso and head. Lestari screamed in pain. When the baby came out, it was already dead. Lestari was very sad with the loss of her baby. She paid the *bidan* Rp. 300,000 from her savings for her assistance. After the delivery, her vagina became so swollen that she could not walk for five months.

During her second pregnancy, Lestari went to a *bidan* who had a practice 3 km from her house. She also consulted a *dukun*. This time, the birth, which was attended by both the *bidan* and the *dukun*, was normal without any difficulties. Lestari safely gave birth to a baby girl. The *dukun* asked for Rp. 400,000 because she washed Lestari's and her baby's clothes every day for one month. The *bidan* also asked for Rp. 400,000 for her childbirth services. So Lestari paid a total of Rp. 800,000. This was a very heavy burden for Lestari. Fortunately, the *bidan* allowed her to pay in installments.

There are many cases similar to Lestari's in Indramayu.

Table 5.5.
Factors that Influence the Choice of Childbirth with the Assistance of a *Bidan* in the Seven Research Areas

Reasons for choosing a *bidan*	Reasons for not choosing a *bidan*
1. In several regions, the local government provides free childbirth services attended by a *bidan* through Askeskin or JKJ (in Jembrana). 2. *Bidans* have better and more complete equipment than *dukuns*. 3. Close emotional relationship between the *bidan* and the patient. 4. *Bidans* are willing to go to the patient's house. 5. Medicines prescribed by *bidans* are effective. 6. Information disseminated by *posyandu* regarding the importance of having routine examinations with the *bidan*. 7. *Bidans* are relatively closer and easier to reach than doctors. 8. There are more *bidans* than doctors. 9. Payment for *bidans* is flexible (in certain cases, the patient can pay in installments and payment could be waived if the patient is unable to pay). 10. Women tend to choose *bidans* when they have high risk pregnancy. 11. *Bidans* are women. Some women in North Lampung refused to be examined by male doctors for religious reasons. 12. Women who have had problems in previous pregnancies tend to choose *bidan* to assist in childbirth.	1. Many b*idans* do not live in their practice area in the village and they are rarely at home. 2. Although treatment by a *bidan* is free, patients are embarrassed if they do not give her something as a sign of their gratitude for her services. 3. *Bidans* do not clearly state their fees so the patients are confused about how much to pay them. 4. In several cases, the *bidan* is not very friendly particularly to patients who use Askeskin, and are not as caring as *dukuns*. 5. The number of *bidans* is limited in remote areas and in some regions there are none available. 6. The cost of childbirth attended by a *bidan* is expensive for poor patients who do not have Askeskin, i.e., from Rp. 350,000 to Rp. 600,000. Difficult births may cost as much as Rp. 1 million. 7. The *bidan* works in two venues, i.e., at the *puskesmas* and also in her private practice at home, so sometimes she is not available. 8. Some *bidans* are willing to assist births at the patients' homes, but some are not willing to do this, especially if the home is very small and does not have clean water. 9. The distance to the *bidan*'s practice is very far and requires a long time to reach, so the patient must think twice about contacting the *bidan*. 10. The *bidan* may perform an episiotomy, while a *dukun* will not do this. For this reason, patients tend to choose the *dukun*.

CHAPTER VI
The Authority over Women's Bodies and the High MMR

"Women are dying not because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving."[1]

These words of Prof. Fathalla remind us of the various cases that WRI encountered in the Focus Group Discussions (FGD) concerning strategies to encourage the government to allocate funds for the reduction of the MMR. Participants of the FGDs included various stakeholders, such as members of local communities, *bidans*, other health service workers, members of community organizations, etc. In one discussion in the city of Banda Aceh, one participant spoke of the following case:

> "One mother who had routinely gone to the Village Maternity House (*polindes*) for pregnancy exams felt confident about giving birth at home because, according to the *bidan*, there were no problems with her pregnancy. When she gave birth at home, she was assisted by the *bidan*. However, after the baby was born, she experienced heavy bleeding. The *bidan* urged the husband to take her to the nearest hospital to get emergency medical treatment. Her husband replied

[1] Prof. Mahmoud Fathalla 1997, Former President of FIGO Professor of Obstetrics and Gynaecology, Asslut University, Egypt.

> that he could not make an immediate decision because he had to consult with his parents and his in-laws first. After a lengthy discussion, the husband told the *bidan* that 'the family decided that lives were in the hands of God and if his wife should die, then let her die at home. The *bidan* was very sad because she could not do anything to make them change their minds. She desperately tried to stop the heavy bleeding. Because she did not have sufficient equipment and there was no IV or blood transfusion available, she failed to save the mother."[2]

WRI encountered many such cases during interviews and FGDs. Women still do not have authority over their own bodies because their husbands and families are the ones who make the decisions regarding their bodies. The reality of gender inequality that puts women at the bottom of society is one of the most difficult obstacles to overcome in the effort to reduce the MMR in Indonesia. Programs that are aimed exclusively at improving the quantity and quality of equipment and the capacity of health workers have not been sufficiently effective in reducing the MMR. Education about gender equality and gender justice to promote equal respect to women's and men's lives is one of the most important determining factors for a successful program to reduce the MMR.

This chapter invites us to understand how unequal gender relations are manifested in various social forms and have conditioned women as the poorest and most marginalized in the society. Much of women's poverty is rooted in the differences in gender roles that are reflected in the unequal conditions and positions of women and men in society.

Gender Inequality and Women's Double Burden

Gender inequality that is based in patriarchal values heavily influences the relationship between men and women. Patriarchal values that place

[2] Interview with FGD participant in Banda Aceh, August 22, 2007.

men in a higher position than women are manifested in the division of gender roles where women are placed in the domestic realm, while men are active in the public domain. In fulfilling their role, women start working from early in the morning, before the rest of the household members wake up, and continue until late at night, after the rest of the household members have gone to sleep. Poor women in West Sumba must wake up at dawn to cook breakfast for their husbands who leave to work in the fields, take care of their children, and during the dry season they must walk almost two hours to fetch drinking water from a freshwater spring in the middle of the forest. The length of the women's working day does not improve their her economic situation because she is not paid for her domestic chores.

In many cases, women must also work to earn income for their families, thus creating a double burden for them as both income earners and domestic workers. The double burden is harmful to women's reproductive health since women, even when they are pregnant, must continue to work from morning until night. In rural areas, pregnant women continue to work in the fields or fetch water from public wells that are far from their homes, while their nutritional intake does not improve.

Poor women in West Sumba, for example, must help to support their families by assisting their husbands working in the rice fields from morning until evening. When the planting season is over, they weave cloth, which they sell to pay for daily expenses. Many poor women accept weaving contracts, where the person who places the order provides all of the materials for the cloth. One piece of cloth could take 7 to 14 days to weave and they sell it for around Rp. 10,000 to Rp. 100,000, depending on the level of weaving complexity. As one respondent said:

> "If we don't work, we don't eat. We don't mind getting tired as long as we can feed our children and families… It's hard to find food and in Sumba, and I don't get much from selling vegetables in the market."[3]

[3] Interview with a vegetable vendor in Waikabubak, Ina Sode, December 20, 2007.

During the vegetable harvesting season, the women walk up to 7 kilometers to the market to sell their vegetables for approximately Rp. 20,000 to Rp. 40,000 per load. They get very little money because the vegetables they sell are usually just cassava leaves, papaya blossoms, and edible tubers and roots. In rural Central Lombok, during the planting and harvesting seasons women must assist their husbands as farm laborers. Women receive wages between Rp. 10,000 to Rp. 15,000 per day, while men receive between Rp. 15,000 to Rp. 25,000 for a half day's work.[4] If they are paid in rice, then their wages are calculated based on the amount of rice they harvest in the day. Women in the Pujut subdistrict become cattle or buffalo herders when the harvesting season is over. The cattle and buffalo owners pay them with the offspring of the livestock that they herd.

In Surakarta, it is not rare to find vendors in the traditional market-place or in Klewer market carrying their young children while selling their wares.

> "As women, it is our responsibility to take care of our children and our husbands, beginning with cleaning the house and doing the washing and cooking. Even though we are busy selling goods in the market, we must finish our housework first."

Another woman added:

> "I usually take my child to the market with me ... What else can I do? ... She's too young to be left at home. It's better that I bring her here rather than leave her at home alone. Of course, it's a bit of a bother, but I'm used to it...."[5]

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[4] Results of observations and discussions with farmers in Ketare village and Sengkol village, Central Lombok.

[5] Interview with Sularni from Sangkrah subdistrict, Pasar Kliwon, August 8, 2007.

Ani from Indramayu said that almost all of her time was spent working either in her home or in the rice fields. She worked as a farm laborer and must wake up very early in the morning when it was still dark to cook and prepare breakfast for her family. Then she went to the rice fields to work all day. Upon returning home, she cleaned the house, washed clothes and took care of her children. In short, she had no time to do anything else, such as going to a healthcare facility for medical treatment. Ani said that she has never been treated medically when she felt ill.[6] The burdens of working both in and outside the home limit the ability of women to access public health service facilities.

Although women play a double role as domestic workers and income earners, meaning that they are also active in the public sphere just like men, patriarchal traditions and social values prevent them from claiming authority over their own bodies and reproductive life. Men remain the decision-makers in the household. Women must acquiesce and follow the one-sided decisions made by men, including the decision about who to ask for assistance in childbirth. As one respondent explained, women tend to follow their husbands' decisions to ask a *dukun* to assist in childbirth.[7]

> "When I gave birth, I was helped by a *dukun* that my husband called. It was actually against my will, but since he had called the *dukun*, I went along with the decision. Besides, even if I wanted to call a *bidan*, I wouldn't be able to pay because *bidan* was expensive."

Gender Inequality and Women's Reproductive Health

Table 6.1. shows that the percentage men seeking medical treatment at a hospital or from a doctor was higher than women because the treatment was more expensive and men were much more mobile than women. It is

[6] Interview with Ani, Indramayu, August 2007.

[7] Based on an interview with a respondent from Cikarang village, Muncang subdistrict, district of Lebak, April 2008.

Table 6.1. Choice of Place for Treatment when Sick

No	Choice of Place of Treatment	Lebak		North Lampung		Sumba		Surakarta		Jembrana		Central Lombok		Indramayu	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F
1.	Hospital/ Doctor	11.3	6.8	17.5	16.6	20.4	14.6	39.6	32.5	63.1	54.7	26.4	27.4	20.8	14.3
2.	*Puskesmas/ Puskesmas pembantu*	24.5	28.8	30.2	31.8	48	59.2	23.3	23	4.1	6.2	23.1	26.5	20.1	25
3.	*Bidan*	1.9	8.5	7.9	16.7	1	18.4	2.3	6.8	2.7	12.4	0.8	6.9	8.4	9.5
4.	No treatment/Buy medicine at local food stall	49.1	56	30.2	34.8	12.3	9.7	25.6	38.9	19.2	25.5	29.8	38.4	36	50.5

Source: WRI survey results in seven research areas, 2007

difficult for women to leave their homes to seek treatment because of their double burden as both domestic workers and income earners. The women respondents said that they did not go to hospitals because they were too far (in the district center or city) and too expensive (they did not want to spend the money on themselves). More women would rather seek treatment at the *puskesmas* or *pustu*, or consult a *bidan,* because they were closer and less expensive.

Another reason why fewer of women sought medical treatment was the difference between men and women in their perception of illness. Men see illness as anything that bothers their state of health. Women however, perceive illness as a condition that prevents them from executing their daily domestic activities, such as cooking, house cleaning, washing clothes, and taking care of children. Several women respondents in the research areas said that they did not consider having a headache or fever as being sick because they could still do their housework. Only if they could no longer get up from bed did they feel that they needed treatment. On the contrary, men tended to react more quickly to ailments because there is a general assumption in the society that men are the primary breadwinners, so the tendency is to prioritize their health over women's health because housework does not have an 'economic value'. Table 6.2. shows that many women just bought medicine at the local

food stall whenever they felt ill. The choice of place of treatment is very much influenced by the capability of the members of society to pay for services, accessibility of the society to use health services and infrastructure, and the patriarchal values that form the perceptions of illness in the society.

Data from the Gender Development Index below shows that the life expectancy of women was lower than the life expectancy of men in all of the WRI research areas. According to WRI research findings, a great number of women did not express pain or discomfort because all of their domestic, economic and social roles and responsibilities left them with no time to seek treatment. What is interesting from the data presented below is that in six research areas with the exception of Surakarta, the rate of literacy was higher amongst women than amongst men. The reason for this is that since males were expected to support their families, many of them left school at an early age to find work. Thus, gender roles apparently are also detrimental to males in regards to formal education.

Another interesting point is that, except for Surakarta, women contributed more to the family income then men. This provides more proof that women do indeed work in two spheres, i.e., domestic and public, to

Table 6.2.
Gender Development Index (GDI), 2002[8]

No.	Province/ District/City	Proportion of population (%)		Life expectancy (years)		Literacy (%)		Average number of years in school		Contribution to income	
		F	M	F	M	F	M	F	M	F	M
1.	City of Surakarta	47.9	52.1	69.1	73.0	89.3	96.8	9.2	10.5	33.2	66.8
2.	North Lampung	50.2	49.8	63.4	67.3	97.7	94.3	7.6	6.8	65.8	34.2
3.	Jembrana	50.1	49.9	68.5	72.4	91.3	81.6	7.9	6.3	71.1	28.9
4.	Indramayu	49.7	50.3	61.8	65.6	85.1	67.4	5.8	4.4	80.9	19.1
5.	Lebak										
6.	Central Lombok	46.8	53.2	55.7	59.2	78.4	59.8	5.9	3.9	55.6	44.4
7.	West Sumba	50.1	49.9	60.5	64.2	74.9	68.4	5.6	5.0	60.4	39.6

[8] Indonesia Laporan Pembangunan Manusia 2004, Ekonomi dari Demokrasi, Membiayai Pembangunan Manusia Indonesia, BPS, Bappenas, UNDP.

support their families. It can also be said that women's incomes are used for household needs, while men's incomes are used for their personal needs. It is not rare that men use their incomes to marry again. Therefore, they must support more than one wife, and their wives must work as well to support the needs of their own households. The district of Indramayu is interesting to analyze. Women's contributions to the family incomes were far greater than the contribution of men. It means that girls and women in Indramayu were assets to their families, as discussed in the previous chapter.

More information on gender inequality can be seen in the data presented in Table 6.3., which shows that the level of participation of women in parliament in all of the research areas was very low. In Jembrana and West Sumba, there were no women at all in the local parliament. This is an important finding because the low level of women's participation in parliament means that public policy in the districts was dominated by men's interests and needs. Thus, men dominated the formulation of government programs and activities. It is apparent that there is a positive correlation between patriarchal values and the small number of women in decision-making positions in the public sphere in these areas.

Table 6.3.
Gender Empowerment Measurement (GEM) 2002[9]

No.	District/City	Women's Participation in Parliament (% of members of parliament)	Women in Professional, Technical, Leadership, & Administrative Positions (% of total)	Women in Workforce (% of total)	Women in Population (% of total)	Average Wages in Non-Agricultural Sector (Rp)	
						F	M
1.	City of Surakarta	2.2	51.3	43.6	52.1	297.7	461.8
2.	North Lampung	6.7	56.9	38.1	49.8	528.4	626.9
3.	Jembrana	0.0	38.6	43.3	49.9	314.3	591.1
4.	Indramayu	2.2	42.6	35.2	50.3	318.9	731.8
5.	Lebak						
6.	Central Lombok	6.7	28.2	50.4	53.2	273.5	348.7
7.	West Sumba	0.0	36.8	44.2	49.9	431.0	520.2

[9] *Ibid.*

Authority over women's bodies and the choice of contraceptive cevice

Table 6.4.
Use of Contraceptive Devices

No.	Contraceptive methods currently used (%)	Lebak	North Lampung	Sumba	City of Surakarta	Jembrana	Central Lombok	Indramayu
	Men	0.4	2.2	5.2	23.2	2.4	6.2	2.8
1.	MOP	0.0	1.0	2.0	0.0	0.4	0.0	0.0
2.	Condom	0.0	0.0	0.0	13.6	1.2	1.8	2.4
3.	No contraceptive	0.4	1.2	3.2	9.6	0.8	4.4	0.4
	Women	75.3	78.1	36.8	42.8	81.3	69.1	80.9
1.	Pill	14.5	20.3	11.1	11.1	8.8	16.4	24.3
2.	IUD	0.0	1.7	1.6	7.1	5.6	13.3	4.0
3.	Injection	74.0	76.8	73.8	56.6	76.5	63.3	65.7
4.	Implant	11.9	0.8	0.0	1.5	6.4	4.9	1.6
5.	No contraceptive	24.3	19.7	58.0	34.0	16.3	24.7	16.3

Source: WRI survey results in seven research areas, 2007

Table 6.4. shows that far more women than men used contraceptives in the seven research areas. This is related to the family planning services program that was aimed more at women, both in terms of dissemination of information and availability of contraceptive devices. The family planning program and policy that is aimed more at women shows that the government perceives women's bodies to be more easily regulated. Many kinds of contraceptive devices are inserted into women's bodies without consideration of their effects on women's health. Often, it is not the woman herself who makes the decision and selection of which contraceptive device to use, but rather the husband or the health worker. This means that women do not have authority over their own bodies in making informed decisions about when to become pregnant, how many children to have, and how to prevent unwanted pregnancies. Meanwhile, the health workers said that it was difficult to convince men to use condoms. Almost all of the women who were interviewed also said that their husbands refused to use condoms.

Table 6.4 also shows that more than half of the women used contraceptives to prevent pregnancies, except in West Sumba and Surakarta, where the percentage of use was less than 50%. The low number of family planning participants in West Sumba (36.8%) was due to insufficient facilities accessible by Sumbanese women, as well as cultural factors that determine boys as the carriers of the family name. This belief places a burden on women to give birth to a boy. Thus, contraceptives are not used until a son is born in the family. This, of course, has negative implications on women's reproductive health. Not participating in family planning increases the potential for women to have high-risk pregnancies because of too many children pregnancies that are too close to each other or the age of the mother is either very young or past normal childbearing years.

Meanwhile, there is a different explanation for the low number of female family planning participants in the city of Surakarta (42.5%). The city government of Surakarta has been focused on providing information regarding family planning to both men and women. The local government has a program called *Pria Utomo* ["Exemplary Men"] that targets men and invites them to actively participate in regulating the spacing of children in their families with the use of contraceptives. In order to increase the number of family planning participants, the local government provides sufficient supplies of contraceptive devices in every *puskesmas*, *pustu*, *pusling*, and even *posyandu*. Surakarta is considered to be a major city that offers much better access to family planning information to the public. This influences the general awareness of gender issues that makes it possible for women to ask their husbands to use condoms or for men to choose to use condoms. Therefore, compared to the other six areas, Surakarta has the highest percentage of men participating in family planning. This reflects the beginning of the growth of male participation in family planning programs to prevent pregnancies.

Santi and Health Problems related to Contraceptive Devices
Pasar Kliwon ward, Sangkrah subdistrict, Surakarta

Santi was born on August 21, 1969. She was 39 years old when she was interviewed. Santi, a housewife has been pregnant and given birth five times and has never suffered a miscarriage. The space between her children was very close. When her fourth child was one month old, Santi became pregnant with her fifth child so when fourth child was not yet one year old, and Santi gave birth to her fifth child. Because the babies were only 10 months apart, Santi had difficulties nursing her youngest child. The two infants took turns nursing because Santi could not afford to provide infant formula for her fourth child.

Santi initially used contraceptive pills provided free-of-charge by the *puskesmas* for Askeskin cardholders. When the pills made her feel sick, she reported it to the workers at the *puskesmas* and changed to taking the three-month contraceptive injection, which the *puskesmas* provided for free. After the birth of her fourth child, she had an IUD inserted. Although she had headaches after the IUD was inserted, Santi did not consult the health workers at the *puskesmas* until she noticed signs of pregnancy. At first, she did not believe that she could become pregnant again. The doctor who examined her said that she was indeed pregnant and that the IUD was no longer in place.

Sexually Transmitted Diseases (STD) is a sign of women's poor reproductive health

Table 6.5. shows that the majority of women respondents (more than 50%) in the seven research areas admitted that they had experienced symptoms associated with sexually transmitted diseases (STDs). The most common complaint mentioned by the respondents was unusual vaginal discharges, followed by itchiness in the vaginal area.

The district of Indramayu recorded the highest number of respondents who had experienced STD symptoms, reaching 82.7%, with the

Table 6.5.
Respondents who have STD Symptoms

	Lebak	North Lampung	Sumba	City of Surakarta	Jembrana	Central Lombok	Indra-mayu
Have STD problems	62.0	56.3	72.7	67.3	40.3	81.0	82.7
Types of Problems:							
Pain/discomfort in vaginal areas	8.7	6.7	26.3	8.7	4.7	26.3	18.7
Boils and warts in vaginal areas	3.3	1.0	6.7	0.7	0.7	5.7	6.0
Itches in vaginal areas	27.3	23.0	36.7	32.7	18.3	41.0	41.7
Unusual vaginal discharges	54.3	46.0	65.0	57.7	33.3	60.0	71.7
Inflammation in vaginal areas	7.3	2.3	23.3	3.0	1.3	10.7	5.3
Pain during intercouse	12.7	8.0	27.3	10.0	5.3	20.0	17.0
Post-intercourse bleeding	4.0	2.0	13.3	2.0	1.7	8.3	2.3
Cramps in lower abdomen	18.0	17.0	40.7	25.0	13.0	48.7	37.7

highest percentage of two STD symptoms, i.e., unusual vaginal discharges and itchiness in the vaginal area. Apparently, these two STD symptoms were closely linked to a local custom called *luruh duit*, 'reaping money', that encourages many women in their productive years in Indramayu to become commercial sex workers to earn an income for the family. This tradition will be discussed in more detail later in this chapter.

Knowledge and awareness of reproductive health amongst women is, in general, still very low, so the potential of STD infection is extremely high. This is closely related to the very low percentage of men who use condoms during sexual intercourse. It also reiterates the fact that women do not have authority over their own bodies so their control of their own reproductive health is very weak. Many women admitted that they prefered to drink traditional remedies or take antibiotics that are sold without prescriptions to treat their STD symptoms rather than going to a health service facility to get medical treatment. Table 6.6. shows the various choices of action taken by women respondents when they experienced STD symptoms.

Table 6.6. shows that the great majority of women respondents who experienced STD symptoms, averaging over 60%, chose not to undergo medical examinations. The interviews revealed that the women respondents in the research areas were embarrassed to have their vaginal areas

Table 6.6.
Choices of Place for Treatment of STD Symptoms

Choice of Treatment	Lebak	North Lampung	Sumba	City of Surakarta	Jembrana	Central Lombok	Indramayu
No examination	72.2	72.8	70.8	70.8	73.6	81.9	63.7
Dukun/traditional	11.8	13.6	1.8	10.9	3.3	3.7	18.5
Bidan/private doctor	8.0	4.1	3.7	8.9	23.1	4.5	14.1
Puskesmas/*Pustu*/Nurse	5.3	7.7	17.3	6.9	0.0	7.4	3.6
Posyandu/*Polindes*	2.1	1.2	4.1	0.0	0.0	0.0	0.0
Hospital	0.5	0.6	2.3	2.5	0.0	2.5	0.0

examined when they suffered the symptoms. Many women admitted that they would be embarrassed if other people, including their husbands, found out about the symptoms, and they were afraid that they would be blamed and considered to be 'bad' women, even though they were infected by their husbands or sexual partners. Also, many women considered that several STD symptoms were not unusual conditions that needed to be treated. They assumed that the symptoms would eventually disappear without treatment.

Only a small number of women were aware of the need to be examined at healthcare facilities or by a *bidan*. This is a serious matter since STD symptoms should not be ignored because they could spread to other sexual partners or trigger more serious illnesses that have negative effects on the reproductive health of women and, in the case of a pregnancy, the fetus. Most of the women respondents were not aware that they could have contracted their STD symptoms from their husbands or sexual partners. Because of their minimal knowledge about women's reproductive health, there have been no efforts to prevent the spread of infection between partners.

Meanwhile, few health workers and healthcare facilities provide specific information and treatments related to women's reproductive health. It is only the city of Surakarta that has a healthcare facility a *puskesmas* located in the Sangkrah subdistrict which is specifically for STD treatments. One health worker in the Sangkrah *puskesmas* explained that the health workers began their work by developing trust with their patients,

especially the ones that suffered from HIV/AIDS, guaranteeing anonymity of the patients so they would agree to be examined. They were also proactive in approaching groups with high-risk of contracting STDs and HIV/AIDS to encourage them to be examined, and even to make special appointments with guarantees to keep their identities and medical complaints secret.

However, the efforts of the health workers in Surakarta to improve access of STD sufferers to healthcare facilities had not significantly increased the number of patients who go to health facilities for treatment of their STD symptoms. The percentage of women who chose not to have themselves examined was still as high as 70.8%. Insufficient information regarding their reproductive health and the discriminative cultural traditions and taboos still present a stumbling block for women to pay more attention to their bodies and reproductive health.

Local Cultures that Marginalize Women

Women in WRI's seven research areas live within patriarchal social and cultural relations that place them positions in which they are unable to make decisions regarding their own reproductive life. Women cannot determine for themselves whether they want to engage in sexual intercourse or not, whether they want to have children or not, and whether they want to be taken to a health facility or not when they suffer bleeding and complications during childbirth. The husbands and the families control their bodies and lives.

Many religious perspectives do not support women in having authority over their own bodies. Some religious interpretations claim that when the husband demands sexual intercourse, it is 'forbidden' for the wife to refuse. Some interpretations go so far as to claim that the wife will be cursed if she refuses her husband's desire sexual intercourse, even though in certain circumstances, intercourse can endanger the woman's

reproductive health. Women's authority over their bodies is not recognized by many social, cultural and religious values.

The following accounts concern local cultures in some of the WRI research areas that deny the rights of women to make decisions regarding their life in general and reproductive health in particular. In order to reduce the MMR, we need to go beyond providing adequate health facilities, equipment and health workers. We need to promote cultural changes that would allow women to make decisions regarding their lives and reproductive health.

In West Sumba, women are bought and brought into the husband's family

In West Sumba ancient traditions, perspectives and social values have indirectly contributed to the weak position of women within families, the society and in other social relationships. For example, there is the tradition of *belis*, which is the amount of money and property given by the bride-groom's family to the bride's family. For Sumbanese men, *belis* is often seen as a transfer of rights of the authority over the woman from her birth family to her husband's domain. The woman becomes the property of the husband and his family.

Young girl taking care of her younger sibling in an impoverished area in Indramayu

> "When the woman's family accepts the *belis*, after the wedding the woman joins her husband's family and becomes an accessory in their family and societal relationships. Family traditions also include the custom of *ganti suami*, which means that if a man dies, his widow must marry the dead man's surviving brother." (Hadikusuma 1990:73).

In general, *belis* is given in the form of cows, buffalos, horses, pigs, and several pieces of *kombo* (Sumbanese woven cloth). The number of livestock involved in the *belis* may be dozens or even hundreds. In return, the groom's family is given *mamuli*, unique traditional Sumbanese gold jewelry in the form of earrings, necklaces, bracelets, and anklets worn by women in traditional ceremonies. *Belis* often serves as a symbol of wealth and power for men who are able to pay high prices, and also signifies the beginning of a long term relationship between the two families. In an unwritten law of the tradition, the *belis* does not have to be paid promptly to the bride's family at the time of the wedding. It can be paid in installments even after the death of the couple. The children of the couple might have to continue paying for the installments. This symbolizes that the bond between the two families will never be broken.[10]

A wife must be completely obedient to her husband in all matters, even when she is subjected to physical, economic and psychological violence. There is a traditional saying from a mother to her daughter in regards to domestic problems, "Even if you are beaten by your husband or father-in-law, don't you dare to come home! It is shameful to come home!" This means that no matter how badly a woman is treated by her husband and parents-in-law, she must accept it. Parents are ashamed to receive their daughters back into their homes once they have been married. Therefore, wives must endure domestic violence without any support or assistance from their families.

According to Ety Rambu Baba, a woman activist in West Sumba,

[10] Interview with Jack Karimata in West Sumba, December 21, 2007.

> "In Sumbanese society, the rate of violence and unjust patterns of relationships experienced by women is still very high. Many women cannot complain about their problems to their parents because they have already been released from their parents' care and are in the full custody of their husbands and the husband's families. Women cannot leave their husbands because West Sumbanese society does not recognize divorce. Women must accept their situations without being able to do anything about them."[11]

The word 'divorce' is unknown in Sumbanese society. Once married, a couple remains together for the rest of their lives. The consequence of an expensive *belis* from the groom's family is that in the case a couple does part, the bride's family must return the value of the *belis* to the groom's family. Inevitably, the woman is blamed for the failure of the marriage.

As a consequence of the *belis* tradition, women cannot participate in decision-making, which remains in the domain of men. For example, in the wedding ceremony, there are no women allowed to be present during the *belis* process and meetings of the two families. The women stay in the back, preparing food for the male guests. The architecture of the house also accommodates gender polarization. Traditional houses in Sumba[12] usually have two doors. The main door is for guests and men, while the back door is used for activities associated with women.

Subjugating Sasak women through marriage

There is a tradition amongst the Sasak, the ethnic majority in Lombok, called *merariq*, in which a man kidnaps the woman of his choice. The woman is taken to the house of a relative of the kidnapper, who then informs the woman's family that the kidnapper will propose formally.

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[11] Interview with Ety Rambu Baba, a female activist in West Sumba, December 7, 2007.

[12] "Pulau Sumbawa, Tawaran Berwisata ke Masa Silam", *Sinar Harapan* newspaper, http://www.sinarharapan.co.id

Although many women do not agree with this tradition, it is still practiced. One woman stated that:

> "If the one who kidnaps her is not her choice, but comes from a family that has a high social status, the woman doesn't dare to refuse the family and oppose the tradition. Rebellion does not provide any solution. She must marry the kidnapper."[13]

This tradition positions women as objects of conquest, something to be claimed and owned by force. Another Sasak tradition results in the women losing support from their families. A Sasak woman who marries a man whose social status is lower than hers will be disowned by her family, and her parents will not attend her wedding. On the contrary, Sasak men will never be disowned their families and they can marry any woman from any social class.

Those two traditions place Sasak women in a disadvantaged position. Sasak women do not dare make decisions for themselves. The husbands determines how many children they should have and when to engage in sexual intercourse. WRI's survey results show that only 2.3% of the women respondents in the district dared to make decisions about how many children to have in the family. The majority, 57.7% of them, would not even go for health examinations if they did not have permission from their husbands.

Marginalizing women in North Lampung through marriage and inheritance

Similar to the Sasak tradition in West Lombok, marriage in Lampung is bound by a bride price (*ngakuk mulei*) presented by the groom's family to the bride's family. The bride price signifies the transfer of "ownership" from the woman's family to the husband and his family that basically lasts forever. Divorce is very rare in Lampung. Traditionally, divorce is forbid-

[13] Discussion with women of high social status in Batujai village, Central Lombok.

den. It is said that there should be no divorce except through death. Those who do get divorced bear a burden of shame, not just for themselves, but also for their families. Therefore, couples choose to remain married even though they are not happy. In cases of domestic violence, the woman often chooses to remain silent because, in accordance to the interpretation of Islamic tradition, she should protect the reputation of her husband. It is forbidden for a wife to speak out in public about their husbands' violent behavior.

Women in North Lampung are also denied of their rights of inheritance. In accordance with the patrilineal character of the society, the oldest son inherits the authority and assets of the family from his father. The inheritance of power from father to son positions women as secondary family members who do not have access to either authority or ownership of productive family assets. Since women do not receive any inheritance, they become economically dependent upon men – their fathers, husbands or brothers. It is very difficult for women who do not have their own incomes and economic assets, especially if their formal education is limited, to make decisions in the family, let alone to divorce their husbands.

Subjugating women into sex workers in Indramayu

Indramayu is a geographically strategic area because it is on the main north coast highway of Java, which is a main artery of the national economy. Because of this, Indramayu has become a stopping place for new arrivals and there has been contact between the local culture and many other cultures. The *luruh duit* tradition is widely known in Indramayu and is associated primarily with women who become commercial sex workers to help out families. In Indramayu, it is not strange for a mother to prepare her young daughter to become a sex worker as she matures. The community accepts the phenomenon of parents selling their daughters or even a husband selling his wife in the framework of *luruh duit* without any negative labeling. These *luruh duit* women who are successful

in lifting up the economic status of their family are honored as heroines by their family members. It is not rare that before a young girl leaves for the city, the family will hold a prayer gathering that is led by the local religious leader to pray for her safety and ease in finding good fortune in the city.

The *luruh duit* tradition treats women basically as sex objects and it raises the risk of health problems related to women's reproductive health. WRI's survey of women in four villages in Indramayu revealed that they had more reproductive health problems compared to women in the other six areas. The survey results also show that only very few women who had STD symptoms had gone for examinations at the health service facility in their area. Most of them (46.7%) chose to treat themselves, while others either ignored the symptoms or did not treat them at all. It is very difficult for women in Indramayu to make decision regading their own reproductive health.

Subjugation starts with marriages at a young age

Marriage at a young age is a tradition that cuts across local cultures. The tradition of early age marriage is also an obstacle for women to be able to make decisions concerning their reproductive life. Many women in rural areas marry at the ages of 13 or 15. This tradition is rooted in several factors, including economic difficulties. For a poor family, a female child is both a burden and an asset. Marrying off a daughter may be the best way for an impoverished family to free itself of one of its 'burdens'. These values represent social forms that have existed for generations and have been reinforced by poverty.

In Central Lombok, poor families regard their daughters as investments and arrange to have them married when they are as young as 15, or even 13, years old. They are often offered to the religious teachers in the area, because these teachers are respected and considered to be economically stable and able to support two, three or even four wives. The phenomenon of young age marriages is also found in Indramayu in the pro-

vince of West Java. The average age at first marriage of fertile couples in West Java (including Indramayu) is 17 years old. Data from the 2002-2003 Indonesian Basic Health Survey shows that 126 out of 1,000 women of childbearing age between the ages of 15-19 years in West Java had already given birth. Marriages of young girls are considered to be common, especially in lower and middle classes, because they lessen the economic burden on the family. When they get married at a very young age, virtually still girls, they are not in any position to make decisions regarding their reproductive life. Their position is made worse because poor families usually do not allow their daughters to go to secondary school, let alone higher levels of education.

Religious Interpretations that Marginalize Women

There are many cases of polygamy found in Indonesian society because many people interpret a verse in the Koran as permitting men to have four wives. When interviewed, women respondents in Central Lombok[14] said that they did not want to be in polygamous marriages. However, there is no venue for women to oppose their husbands' wishes because their only choices are polygamy or divorce, in which case they would have to support themselves and their children. The threat of polygamy tends to force women to obey their husbands. There are also many cases of domestic violence after a man takes another wife. Violence is generally the husband's strategy to avoid questions and complaints by the first wife.

Sometimes religious interpretation is enforced by a local tradition. In West Sumba, it is acceptable for a man to marry a second wife if the first

[14] Interview with Sarni from Praya ward, Gerunung subdistrict, Central Lombok: "*..mau pisah dari suami, malu jadi bebalu (janda), biar saja suami kawin lagi, asalkan anak-anak tetap ada bapaknya, malu sama keluarga*" ["…I want to divorce my husband, but I'm ashamed to be a divorcee. Let him marry again, as long as my kids have a father; I'd be ashamed to face my family."], August 12, 2007.

wife is not able to give birth to a son. The majority of the West Sumbanese society prizes sons because they are the *pamaus*, the protectors of the family's wealth and assets. The male children inherit all of the family's wealth because female children are considered to be join their husbands' families and do not have rights to an inheritance from their birth parents. If a family does not have any male children, then the inheritance will go to the father's brothers.

Religious interpretations also heavily influence social perspectives towards family planning. There is a interpretation that Islam forbids the use of an IUD that is inserted into the vagina because the health worker must open the woman's *aurat* to insert the contraceptive device. This religious interpretation simply overrides a woman's choice to use an IUD as a contraceptive device.

Another religious interpretation even goes as far as glorifying maternal mortality. Some communities believe that women who die in childbirth are martyrs who will automatically go to heaven. This viewpoint, which is very detrimental to women and does not encourage the reduction of the MMR, reduces the seriousness of the preparations to assist childbirths. Because of this perception, relatives and members of the community do not make maximal efforts to assist when there are complications in childbirth.

Mutmainah

"Religious Values as the Determining Factor in Number of Children in a Family"

Mutmainah, 46 years, is a housewife. She graduated from elementary school. Mutmainah has eight children from eight pregnancies and has never suffered a miscarriage. Her last child is a girl and was nine months old at the time of her interview. Her husband also has an elementary school education and works as a day laborer. His monthly income was approximately Rp. 600,000, which must support five people in the family.

Mutmainah's family needs about Rp. 156,700 per week for food, while other family expenses amount to about Rp. 261,800 per month. Her husband's smoking habit costs Rp. 35,000 per week or Rp. 140,000 per month. Her family can afford to eat only two times a day.

Mutmainah and her family live in a house that measures 24 m^2, with a cement floor and walls made of wooden planks. She lives with her husband, children, sons and daughters-in-law, and grandchildren. They were Askeskin cardholders.

Mutmainah fits the 3T category, which means that she is too old to give birth, she has too many children, and the spacing between her children is too short. At the time of the interview, her youngest child was nine months old, the same age as her granddaughter. Although she uses contraceptive pills, she also believes that children are gifts from God. Because of her family's economic situation, Mutmainah did not go to a healthcare facility for examinations when she got ill. Her husband did not encourage her to take care of her health and was not present when she gave birth.

Mutmainah did not understand the importance of caring for her reproductive health and she had not received the necessary information from either health workers or the mass media about the 3T risks. Mutmainah also felt that a wife must not refuse her husband's desire for sexual intercourse even when she was exhausted because she considered the act of refusal as a sin.

Some interpretations of Hindu teachings in the district of Jembrana also deny women from receiving inheritance from their birth families and from inheriting the family's temple. This practice limits their opportunities for further education. It is commonly perceived that girls do not need to pursue knowledge and higher education, as one respondent in Jembrana said[15,]

> "Girls are not valued in Hinduism because they do not inherit anything. The family assets are owned only by the boys. The girls also

[15] *Ibid.*

> do not inherit the family's temple. In the Hindu traditions, girls live temporarily in the care of their birth family because they will eventually go to their husbands' family. If a Hindu family has only daughters, usually they will 'buy' a son so that there will be someone to inherit the family's temple. Often they 'buy' the young man who will be their son-in-law."

Another respondent said that[16]

> "In Hinduism, girls tend to be discriminated against in the family. They are not sent to school, and they are allowed to eat only after the boys have eaten. Sometimes they are given only the leftovers. However, now more families feel that since girls do not receive any inheritance, they must be educated to become independent."

These perspectives and customs have led to the impoverishment of women. Since girls do not receive economic assets from their families, they cannot bring any wealth into their marriage. Therefore, because they do not have value in the eyes of the husbands' families, they become subject to unjust treatment. In Jembrana, women cannot become religious leaders, priests, or village leaders. Nor do women participate in the decision-making processes to determine traditional village policies and regulations.

In Surakarta, Javanese values position the wife as *konco wingking*, 'the friend in the back of the house', referring to the kitchen, washing area, and bedroom. Women are not in positions to participate in making family decisions regarding matters such as purchasing land, property or other economic assets. This conception influences the upbringing of girls, where cultural values praise a woman who is clever at cooking (in the kitchen), housework (in the washing area), and servicing her husband (in the bedroom). This local culture is reinforced by a religious belief that wives are

[16] Interview with a respondent in Baler Bale Agung ward, Negara subdistrict, district of Jembrana, March-April 2007.

required to do whatever their husbands want them to do. Some of the respondents said that they were afraid to commit a sin by refusing their husbands' sexual demands.

> "A wife is required to serve her husband well. She must not refuse him if he wants sex … that's forbidden, a sin. Moreso if he's having an affair. Then we have to give better service so that he won't leave us."[17]

As in other areas in Indonesia, many Muslims in North Lampung reject the use of contraceptives to limit the number of children in a family. They choose to submit to 'God's will', as they believe that each child brings good fortune and they do not worry about how to finance their children's upbringing. The use of contraceptives is seen as rejecting good fortune from God. Many women in the research areas had between three to eight children. The belief that many children bring good fortune was found amongst

Two young girls must walk 5 km to access clean water, West Sumba

[17] *Ibid.*

women (families) with low levels of education (at most, if at all, elementary school). Women with higher formal education tended to be more aware of the importance of limiting the number of children in the family.

Authority of Women's Bodies and the High Maternal Mortality Rate

The problems of gender inequality that are based in patriarchal social cultural values as discussed above show that efforts to reduce the MMR should be accompanied with public education concerning unequal gender relations. Government programs that target only the improvement of equipment, infrastructure and service providers, such as medical workers, have been proven to be ineffective in reducing the MMR in Indonesia. Gender equality and justice will make it possible for women to have control of their bodies and lives, which will enable them to make decisions regarding their reproductive lives, such as determining the kind of assistance they want in childbirth; receiving proper nutrition so that they will not suffer from anemia during pregnancy, childbirth and while nursing, and deciding whether or not they want to have sexual intercourse and to have (more) children. Acknowledgement of women's authority of their own bodies will allow them to receive the best affordable service to care for their reproductive health.

Gender inequality and injustice that is rooted in cultural values and religious interpretations contribute to the difficulty in reducing the MMR in Indonesia. Raising community awareness is important for the nurturing of health, especially women's reproductive health, and is a necessity for the success of the programs to reduce the MMR. It should be promoted to public attention that saving women's lives in childbirth is the same as saving the families productive resources. Besides destroying the nuclear family, the deaths of mothers in childbirth reduce productive resources for the family and the community because the contribution of women to the family's income is very high. In many cases, women contribute more to the family's income than men.

Conclusion
One Village, One *Polindes*, One *Bidan*

In 2010, the Human Development Index (HDI) for Indonesia, as published by the United Nations Development Program (UNDP), slipped from 107 to 111. Several of the primary indicators of the HDI are closely related to health, including Life Expectancy, Infant Mortality Rate, and Maternal Mortality Rate (MMR). It is certain that the persistently high MMR in Indonesia in 2009 contributed to the decline in Indonesia's HDI standing.

The high MMR reflects both inadequate availability of reproductive health services for impoverished pregnant women, and the inability of poor women to access reproductive health services. Repeating a question that is proposed in Chapter I, "What should be done if RSUD in the city, the *Puskesmas* in the sub-district areas, and even the *bidans* that live in the center of the villages are considered by impoverished women who live in remote areas too expensive and/or too far away?" Due to the lack of finances, harsh geographical conditions, bad roads, and scarcity of public transportation, the strategy to reduce the MMR should not to pour all of the government's resources into improving public hospitals in the city and *puskesmas* units at the subdistrict level. The strategy should focus on bringing adequate reproductive health facilities closer to the people who

need them. This book argues that in order to overcome the inadequate availability of reproductive health services for impoverished pregnant women, the government needs to issue a "One Village, One *Polindes*, One *Bidan"* policy and allocate a sufficient budget to implement it. The policy should rule that it is the obligation of the government to provide land for *polindes*, and that the land should be centrally located. Currently, since the community must provide the land for *polindes*, they allocate land in remote areas that are not suitable for living. The policy also should rule that the government must provide an adequate budget to equip the *polindes* with electricity, clean water, sanitation, and adequate facilities for delivering babies.

The policy should also establish one *bidan* living in each *polindes*, making her service available 24 hours a day. In order to make it attractive for *bidans* to live in the villages, besides building the *polindes* in a secure location and providing decent living facilities and adequate equipment to assist in childbirth, the government must provide the *bidans* with motorcycles to increase their mobility in delivering services to the villagers, and improve the system to provide speedy reimbursement of Askeskin claims submitted by the *bidans*. To become an effective spearhead for combatting the persistently high MMR in Indonesia, the "One Village, One *Polindes* and One *Bidan"* policy must be supported with public health insurance that is capable of providing protection to people living in remote areas. Public health insurance itself should not be treated as the spearhead for the reduction of the MMR.

The findings of WRI's research in seven districts show that although a majority of the population are covered by government-provided health insurance (Askeskin, which was reformulated by the Ministry of Health in 2008 to become Jamkesmas) or a Poverty Identification Card (SKTM), they do not have easy access to health service facilities because of the considerable distance of the facilities from their homes, which is exacerbated by mountainous landscapes, bad roads, and lack of public transportation. Since transportation costs are not covered by health insurance, those health facilities are not accessible if the poor women must pay

relatively expensive transportation costs to get there. Ideally, all poor women are covered by insurance and they can easily go to a *polindes* in their respective villages to receive delivery assistance free-of-charge.

Jamkesmas itself needs to be improved so that it can effectively support the "One Village, One *Polindes* and One *Bidan"* policy. In the past, the dissemination of information about Askeskin was not effective. Because of this, WRI found that many poor people did not know anything about Askeskin or how to apply for it. The reasons why many truly impoverished families were not recorded as participants are:

- The poor did have access to information about Askeskin; and
- The poor encountered many difficulties in obtaining identity cards because of lack of information, lack of economic resources, or because they were new residents in the region.

The poor have a low bargaining position in comparison to those who use authority and family connections to force neighborhood committee members to include them as Askeskin participants. One *posyandu* aide in Sangkrah[1] admitted that the list of Askeskin participants that was submitted to the subdistrict office was often not based the criteria for impoverished families as set by the BPS. Instead, family connections and other personal and social reasons became the criteria of selection, resulting in residents who were not classified as impoverished gaining access to Askeskin facilities.

The reimbursement system of Askeskin/Jamkesmas also needs to be improved. Currently claims for childbirth deliveries require a long processing time, thus *bidans* are reluctant to provide free service to Askeskin patients. According to regulations, the claim process should take two to three weeks to process, however, in practice, it takes much longer, often up to six months. The slowness of this claim process disturbs the cash flow of the *puskesmas*.

[1] Interview with Ibu Warno in her house, Kelurahan Sangkrah Kecamatan Pasar Kliwon, Surakarta, August 7, 2007.

The problem now is how to effectively push for a "One Village, One *Polindes* and One *Bidan"* policy that is supported by an adequate budget allocation. The primary obstacle to the introduction of such a policy and budget allocation, reframing Prof. Mahmoud Fathalla's quote, is that policy makers, most of them are men, are not yet committed to saving poor women's lives. The reality of gender inequality that results in the difficulties to promote gender-sensitive policies and budget allocations is one of the most difficult obstacles to overcome in the effort to reduce the maternal mortality rate in Indonesia. The "One Village, One *Polindes* and One *Bidan"* policy would succeed in becoming a spearhead for a drastic reduction of the MMR only when it is accompanied by gender equality and justice education for policy makers so that they will understand that women's lives are worth saving.

Success in persuading policy makers to issue policies and allocate budgets to create the "One Village, One *Polindes* and One *Bidan"* policy should also be accompanied by public education in gender equality and justice. Chapter VI discussed many cases of poor women who do not have control over their bodies, and that decisions concerning their lives and deaths during childbirth are in the hands of their husbands and fami-

Mothers show their insurance cards, West Sumba

lies. The persistence of gender inequality in communities that place men in higher positions than women reduces the effectiveness of the "One Village, One *Polindes* and One *Bidan"* policy in reaching poor women who live in the most remote areas. Since women's lives are not considered worth saving, the husbands and families may feel that it is not worth the trouble to take the women who are hemorrhaging and suffering from complications in delivery to a *polindes* that is located just in another part of the village.

The transformation of *Jamkesmas* into *Jamkesnas* (National Health Insurance) would support the effective implementation of the "One Village, One *Polindes* and One *Bidan"* policy. Jamkesnas would fulfill the mandate of Health Law No. 36/2009, Article 5 Clause 1, that states: "every person has the same right to obtain access to resources in the field of health", and Clause 2: "every person has the right to receive safe, quality and affordable health services". This means that the Indonesian government views health service as a right of every citizen. Every person, whether he/she is economically capable or is categorized as poor, has the right to health services. To strengthen the commitment to this right, Indonesia has ratified the Convention for Economic, Social and Cultural Rights in 2006.[2] One of the consequences of this is that the country is required to guarantee the fulfillment of rights for health, including affordable health facilities and the mechanism for legal settlements for violations of health rights. The responsibility of the government to guarantee the health of the community is further strengthened in the Health Law No. 36/2009, Article 20, which reads, "The government is responsible to guarantee the health of the community through a na-

[2] In 2006, Indonesia ratified the Convention on Economic, Social and Cultural Rights via Law No. 11/2006. This ratification confirmed the government's responsibility and role as the duty bearer to fulfill the minimal needs of economic, social and cultural rights of its citizens, including the capability to provide the minimal facilities and expertise in the provision of food, education, health, housing, and employment that assures each individual in the society to a right to livelihood. This responsibility, of course, includes a mechanism of government accountability for the implementation and protection of economic, social and cultural rights. (Source: http://pusham.uii.ac.id/upl/article/id_ekosob1raf1.pdf, accessed on January 18, 2010)

tional social security system for personal health". These regulations indicate that the government must pay for the health insurance premiums for citizens by implementing a Comprehensive Health Insurance program.

Responding to the various proposals in review of Jamkesmas, Endang Rahayu Sedyaningsih, current Minister of Health, expressed her interest in returning to the previous system of health insurance, i.e., reimbursements. To assure the transfer proceeds smoothly, the Ministry of Health is currently examining the existing laws related to the management of health insurance. Furthermore, the Minister of Health explained that the Jamkesmas system did indeed contradict the Law for the National Social Security System (UU SJSN) and the ministry was drafting a road map for a national health program. Gradually, Jamkesmas will become national insurance, and in 2014 a comprehensive health insurance will be in place to cover the entire population. "The government will pay the premiums for the poor, while both employers and employees will pay the premiums for civil servants (PNS)," the Minister of Health explained.[3]

Jamkesnas would icing on the cake to help the effective implementation of the "One Village, One *Polindes* and One *Bidan"* policy. The case of Jembrana shows that if the government has the political will to introduce a health insurance that provides coverage for all residents, the impact is beneficial to the fulfillment of women's reproductive health rights. What makes the case of Jembrana more appealing is that it is categorized as a poor district in the Poverty Index issued by SMERU.[4] Limited resources did not discourage the government of Jembrana from implementing an insurance policy at the district level that provides free healthcare service for all of its residents, including poor women. The health budget allocation per person in Jembrana in 2007 is very high, Rp. 151,043 per person, far higher than in the City of Solo, which is much stronger financially, which allocated only Rp. 65,934 per person. It is not surprising that

[3] *Media Indonesia* Online, Tuesday, November 10, 2009.

[4] Poverty Map, Indonesia 2000, SMERU Research Institute, 2004.

the MMR in Jembrana is very low, i.e., 55/100,000 live births,[5] much lower than the national average, and has already surpassed the MDG target for 2015, which is 102/100,000 live births.

[5] Yuna Farhan, entitled, "Menelusuri Kebijakan Alokasi Anggaran Kesehatan Reproduksi Perempuan di Tujuh Daerah", p. 3 and 23, presented in the seminar "WRI Research Results concerning the Access and Use of Reproductive Health Service Facilities for Impoverished Women in Seven Regions in Indonesia", June 30, 2008.

Attachment
Research Method

WRI's research on the "Access and Use of Reproductive Health Ser vice Facilities for Poor Women in Seven Districts/Cities in Indonesia" combines qualitative and quantitative research methods to examine the difficulties of reducing the MMR. It is hoped that the combination of these methods will provide an integrated illustration of the problems faced by impoverished women in accessing and using reproductive health care facilities.

The quantitative research, which was conducted through a survey that involved 300 respondents in each of the six districts and one city, for a total of 2,100 respondents, was not able to comprehensively explain the unique and specific problems experienced by the women from different educational and cultural backgrounds, social status, and religions. To complement the results of the quantitative research, WRI also used qualitative research methods by conducting in-depth interviews of 30 people in each district/city (totaling 210 people) and organizing Focused Group Discussions (FGD) in each district/city. Each FGD also involved 30 people, bringing the total number of participants to 210 people.

In addition to the surveys, in-depth interviews and the FGD, WRI also documented several case studies that were considered to be representative of the various experiences of women in regards to reproductive health. Through this combination of quantitative and qualitative methods and case studies, it is hoped that a complete picture of the problems faced by poor women in accessing and using reproductive health service facilities will serve as input for decision-makers and policy-makers in determining policies for reproductive health for women, especially poor women.

WRI hopes that this research will contribute to ideas about how to quickly reduce the MMR in Indonesia. This research identifies the various problems faced by impoverished women in accessing and using health-care facilities that encompass not only the quality and location of the health-care facilities and services, but also their families and social cultural issues. This research also identified ways to improve health-care facilities so that women have access to quality health-care services.

Population and Sample

The population of this study is impoverished village groups, especially women. This study was conducted in two phases.

The first phase was conducted in four areas:
1. Surakarta
2. Central Lombok
3. Indramayu
4. Jembrana

The second phase was conducted in three districts:
1. Lebak
2. North Lampung
3. West Sumba

Two areas—Surakarta and Jembrana—were selected because of their local government policies that benefit communities. Two other districts—Indramayu and Central Lombok—were chosen for the study because they have the highest index of poverty in Indonesia, based on data from SMERU Research Institute. The three other districts—Lebak, Central Lampung and West Sumba—were chosen based on the high proportions of impoverished families, the infrequent access of the community to health services, and the poor state of community health.

The research samples consisted of women who had a child of less than three years old (*batita*). Samples were taken from two impoverished areas, one urban and one rural, in each of the selected districts/cities. The selection of the impoverished regions was based on poverty indicators from SMERU's data (poverty index per village based on projected figures: the higher the index, the poorer the village). The selection of mothers with *batita* as the characteristic sample was based on the consideration that they would provide up-to-date information about the use of reproductive health services and programs, such as Mother and Child Health (KIA), Family Planning (KB), and Reproductive Health. Another consideration for selecting mothers with children under three years old was to reduce recall bias.

Research Location Phase I

Surakarta City

The city of Surakarta was selected as one of the research areas because the local government has made efforts to improve women's health. The efforts have led to sufficient budget allocations for women's and children's health services. Surakarta also has a high percentage of available childbirth assistants.

Jembrana District

The district of Jembrana was selected as a research area because the local government has revised the budget to accommodate an innovative scheme to pay for free health-care for its residents. Although the regional government did not design the policy based on a gender perspective, the policy has had a positive effect on women's health in the area.

Central Lombok District

The district of Central Lombok was selected because it is the district with the lowest Human Development Index (HDI), 338, of all districts and cities in the province of West Nusa Tenggara (NTB). This district also has the second lowest HPI (Human Poverty Index) ranking of all districts and cities in NTB, 298.

Indramayu District

This district was chosen because it is the largest supplier of women migrant workers in Indonesia after NTB and East Java. In addition to this, this district has a low Gender-related Development Index (GDI), 325; low Gender Empowerment Measure (GEM), 278; low HDI, 303; and low HPI, 254. This district also has the lowest number of years of residents in formal education in West Java, and the highest IMR after Subang.

North Lampung District

The district of North Lampung was selected as a research location because of it has high poverty rate (33.81%), and a high proportion of its residents have no access to health care facilities (49.1%). Also, the number of childbirths assisted by medical personnel (*linakes*) is only 60.83%, whereas the national *linakes* is 65% (SDKI, 2002-2003). The IMR in North

Lampung is also high, 46.9/1000 live births, which is above the national IMR that, according to the SDKI 2002-2003, is 35/1000 live births.

Lebak District

The district of Lebak was selected because of its extremely low rate of *linakes*, which only came to 36.3%, far below the national *linakes*, its high IMR (59.9/1000 live births) and MMR (594/100,000 live births). The MMR was almost twice that of the national MMR (307/100,000 live births) (SDKI 2002-2003). Although only 12.09% of the population (from 1.1 million people) is labeled poor, a high proportion of areas in the district of Lebak, 52.5%, are without access to health-care facilities. In 2006, the Ministry of the Accelerated Development of Remote Areas selected Lebak as a target district that would receive special assistance (www.kompas.com. *Saijah-Adinda dan Potret Kemiskinan di Banten,* Tuesday, December 5, 2006).

West Sumba District

The district of West Sumba was included in the study because a high proportion of the population is poor, 42.04%, and also because a high proportion of the population, 55.5%, is without access to health care facilities. Also, the *linakes* is only 29.2%, or half of the national *linakes*, and the IMR is high, 59/1000 live births.

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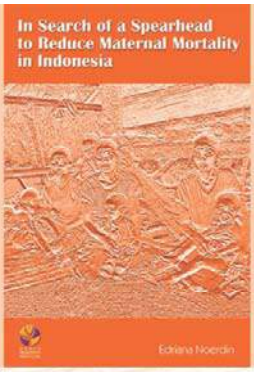

Based on research concerning the access and use of reproductive health services by impoverished women in six districts and one city, this book aims to determine a spearhead to break the persistence of high maternal mortality rate in Indonesia. This book argues that, on the one hand, there is a lack of political will to generate policy and budget allocations to fulfill women's reproductive health needs. On the other hand, poverty, bad road infrastructure, remoteness of residences, and lack of public transportation are reasons that impoverished women living in remote areas consider hospitals in the cities and Community Health Centers (puskesmas) in the sub-districts to be too far to reach and too expensive to afford. Therefore, the government should pass a "One Village, One Polindes, One Bidan" policy and allocate a sufficient budget to bring adequate health facilities closer to the homes of impoverished women in rural areas. Effective implementation of the "One Village, One Polindes, One Bidan" policy does not only depend on budget adequacy. This book argues that successful implementation of the policy also depends on the effectiveness of public education in gender equality and justice to make husbands and families of impoverished women in the remote areas think that women's lives are worth saving. The fact that impoverished women do not have control over their bodies is a major stumbling block to the reduction of the high maternal mortality rate in the country. Education in gender equality and justice should also be provided to policy makers. A comprehensive national health insurance that covers the whole population, including impoverished women living in remote areas, would be an icing on the cake for the effective implementation of the "One Village, One Polindes and One Bidan" policy, however, the successful passage of this policy will requires a sufficient number of gender-sensitive policy makers.

Women Research Institute (WRI) is a research institute that constructs the concept of good governance based on gender equality. It uses feminist methods in all its research. WRI focuses on the impact of decentralization on the political participation of women at the local level.